THE CANADIAN NURSE

L'Infirmière canadienne

VOLUME 55 **NUMBER 2**

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

Editor and Business Manager
MARGARET E. KERR, M.A., R.N.

Assistant Editor
JEAN E. MacGREGOR, B.N., R.N.

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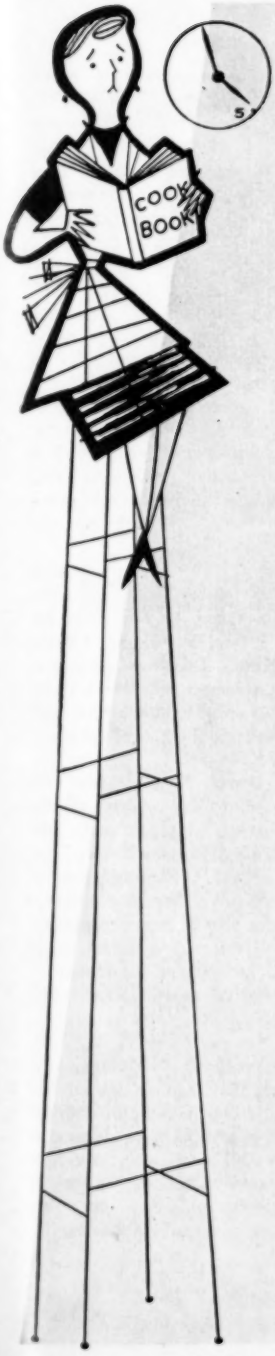

THIS little housewife had a problem — sweet-tooth Hubby on a sweet-free diet. (And beginning to get nervous about it.) She tried everything. Fancy salads. Bigger helpings. But Hubby's frown darkened by the day. Then one day she read in a magazine about a discovery, a new non-caloric sweetener. One that she could actually cook and bake with — in any food, at any temperature. One which gave the perfect taste of sugar — with no bitter aftertaste in ordinary use. That night there were cookies, pudding, coffee — *sweet* coffee — and a big, big smile across the table . . .

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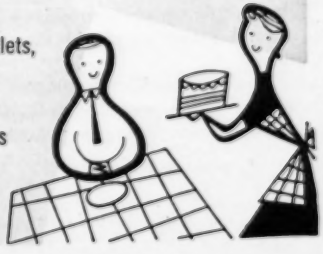


Between Ourselves

Ever since the Alberta Association of Registered Nurses was first formed the provincial office has occupied rented accommodation. As their work expanded they have moved from a corner of one room into offices with several rooms. Now, their moving days are over for a long time to come. In November, their splendid new headquarters was officially opened. Our cover picture depicts the front entrance.

Though committees were responsible for decisions, the person most intimately concerned to see that all details were correctly adapted to make a functional working unit was our guest editor, Mrs. **Clara Van Dusen**. A graduate of Regina General Hospital, Mrs. Van Dusen alternated between private nursing and general staff, with time out for a postgraduate course in Mothercraft, including infant care and feeding. She commenced her work with the Alberta Association in 1949 as registrar, assuming full responsibility for the association's work as executive director more recently.

* * *

With radio and television advertising so often lauding the capabilities of various products to relieve "acid indigestion" most lay people have at least some idea of the significance of the feeling of bloating, of fulness or of actual pain in the epigastric area. They are unaware, however, of the possible relationship of these symptoms to lesions in other organs such as the gallbladder, duodenum or appendix. All of these organs are supplied by branches of the same nerves that go to the stomach. The stomach is such a sensitive organ that it may react quite violently in sympathy with the neighboring organ. The first advice we should give any complainant, therefore, is that he or she should most certainly see her doctor rather than attempt self-medication. Taking any variety of antacid — even bicarbonate of soda — can be very much overdone.

Peptic ulcer is the commonest organic disease of the stomach and the first part of the duodenum. When for any reason a small area of the mucous membrane in either organ is injured and becomes necrosed, the acid gastric juice digests that dead tissue just as it would act upon any piece of dead meat consumed in the course of a meal. Thus a hole or depression is made in the wall of the organ. If uncared for it may extend for varying depths.

The role of the gastric juice in producing a peptic ulcer is easy to understand. The more difficult question is to discover what caused the necrosis in the first place. Since the ulcers occur most frequently in persons who are nervous, restless, irritable, prone to worry and upset by strain, the consensus today is that these factors may combine to produce a spasm in a small artery in the wall of the stomach or duodenum. Lacking nutriment from the blood, the small area becomes necrotic and an ulcer is the end result.

Medical treatment always comes first with these patients. The primary aim is to give the ulcer an opportunity to heal. The descriptions given in the articles by **Carole Eldridge** and **Helen Lemieux** present a clear picture of the importance of thoughtful nursing care as an adjunct to the rest, food and medication ordered by the physician.

* * *

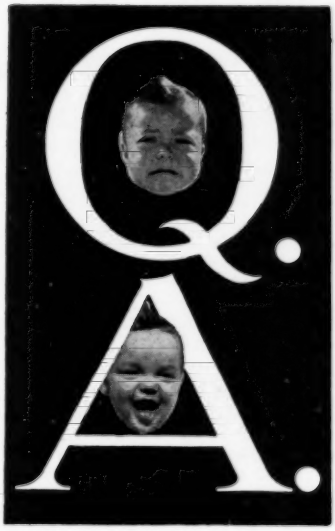
Last summer **Hazel Naudett** was the representative of Canadian nurses on the special tour of Japan arranged under the auspices of the United Nations Educational, Scientific and Cultural Organization. Since her return, Miss Naudett has been besieged with invitations to tell of her experiences. We felt it was of interest to nurses in all parts of Canada as well so asked her to share her story with all of us. You will find it interesting reading.

* * *

We have been inclined to think of the province of Saskatchewan as an agricultural area, far removed from the field of industry. As an instance of how times have changed, a recent survey reveals that there are now thirteen nurses employed full-time in occupational health programs, with four others engaged in this work on a part-time basis.

The days that make us happy make us wise. — JOHN MASEFIELD

Peace is happiness digesting. — VICTOR HUGO



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Edited by DEAN F. N. HUGHES

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Description—Each enteric tablet (entril) contains: Ammonium chloride 7½ gr.

Indications—The treatment of cardiac edema, Meniere's syndrome, pyuria, premenstrual tension.

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Manufacturer—Bristol Laboratories of Canada Limited, Montreal.

Description—Kanamycin sulfate, a bactericidal antibiotic for control of infections caused by a wide variety of pathogenic organisms, both Gram positive and Gram negative.

Indications—Especially in the treatment of infections caused by staphylococci resistant to other antibiotics and in infections of the urinary and respiratory tract. The drug is also suggested for presurgical intestinal antisepsis since it is poorly absorbed from the gut when given orally.

Has not shown cross-resistance with any other major antibiotic.

Administration—Intramuscularly in a total dose of 1 to 2 grams daily in 2 to 4 divided doses.

PROSTIGMIN TIMESPAN

Manufacturer—Hoffman-La Roche Ltd., Montreal.

Description—Each capsule-shaped sustained release tablet contains 45 mg. neostigmine bromide, (the dimethyl-carbamic ester of 3-hydroxyphenyl-trimethyl-ammonium bromide). Offers a more prolonged effect than does the regular form of prostigmin.

Indications—Myasthenia gravis.

Contraindications—Asthma; mechanical intestinal or urinary obstruction.

Administration—Dosage should be individualized according to the patient's response. For control of symptoms in most myasthenia gravis patients, 1 to 3 tablets will be sufficient every 4 hours or more. However, the needs of certain individuals may vary markedly from this average requirement.

TESSALON SUPPOSITORIES

Manufacturer—Ciba Company Ltd., Montreal.

Description—Tessalon (Benzononatine) for rectal administration, 50 mg. and 100 mg. Well-tolerated non-narcotic antitussive. Acts on sensory receptors in the respiratory passages, lungs and pleura, and, it has a central inhibitory action on the cough reflex. It does not impair expectoration, suppress voluntary cough or inhibit the respiratory centre.

Indication—In acute and chronic respiratory diseases for control of cough.

Administration—Adults: 100 mg. suppository 2 or 3 times daily.

Children: 50 mg. suppository 2 or 3 times daily.

When needed, may be given in higher dosages with safety.

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Manufacturer—Ciba Company Ltd., 1235 McGill College, Montreal.

Description—Fluoxymesterone, a new testosterone derivative; provides the potency of injected testosterone esters and up to 5 times that of oral methyltestosterone.

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Indications—In men or women in all cases where an androgenic-anabolic effect is required.

In the female: Menopausal symptoms, menorrhagia, metrorrhagia, premenstrual tension, functional dysmenorrhea and inoperable mammary cancer.

In the male: Symptoms of the male climacteric and hypogonadism.

In both sexes: Osteoporosis and where tissue repair and other anabolic effects are desired, i.e., in burns, paraplegia, catabolism produced by long-term cortisone therapy, delayed healing of fractures, chronic malnutrition, debilitating diseases and convalescence.

Administration—In conditions where a specific sexual effect is desired: initial dosage is usually 2-4 mg. (up to 10 mg. in hypogonadism); maintenance dosage is 1-2 mg. daily.

In conditions were anabolic effects are desired: initial dosage is 4-10 mg. daily (plus high protein diet); maintenance dosage may be as low as 2-4 mg. daily.

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For additional information, write to:

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ENGLISH OR FRENCH?

Everyone is aware by now of the fact that two separate issues of our *Journal* will be published each month commencing with the June, 1959 number. This important milestone in the history of the nursing profession in Canada will be marked by several changes. A smart new cover design for both issues has been approved. We are departing from the dark blue color on the cover that has identified our *Journal* for the past 20 years.

Arrangements have been made respecting publication dates. *The Canadian Nurse,* as the senior issue, takes precedence. It will come from the press at the beginning of the month. *L'Infirmière canadienne* will follow in approximately two weeks.

Currently, the separate mailing list for those who desire to receive the French issue is being built up. The A.N.P.Q. is helping us very materially by indicating with an asterisk those of its members who are English and who will, therefore, be put on the mailing list for *The Canadian Nurse.* All other subscribers in the province of Quebec will automatically be placed on the list of those who will receive the French issue. Any among the latter group who wish to receive the English issue instead are requested to notify the Journal office in writing before *April 15, 1959.* Please give us your registration number as well as your full name and address to avoid the possibility of errors.

Similarly, *L'Infirmière canadienne* will be available to any subscriber who wishes to receive the Journal in French. All that will be necessary is to notify us in writing, again giving the essential information for identification purposes: Your name, address, province of registration and registration number.

Of course, changes can be made later at any time. But every nurse who wishes to make a change in the above-mentioned listing must notify us by **April 15, 1959** if she wishes to receive the June issue.

Such changes will only be made when they are requested in writing. The address to which all of these letters should be sent is:

The Canadian Nurse Journal,
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   (b) Teaching in Schools of Nursing

For further information apply to:

DIRECTOR, SCHOOL OF NURSING
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By LOUIS J. KARNOSH, B.S., Sc.D., M.D., Clinical Professor of Nervous Diseases, School of Medicine, Western Reserve University; and DOROTHY MERENESS, Ed.D., R.N., Director of the Psychiatric-Mental Health Nursing Program, New York University. New. 1958, 5th edition, 406 pages, 5½" x 8½", 37 illustrations. Price, $4.50.

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By FLORENCE K. LOCKERBY, A.B., M.A., Chairman of the Communication Department and Co-ordinator of General Education, Presbyterian—St. Luke's Hospital, School of Nursing, Chicago, Ill. New. 1958, 175 pages, 5½" x 8½", illustrated. Price, $3.75.

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A Dream Comes True

THERE IS A SENSE of real accomplishment when a goal is reached. All the long weary hours of planning, the countless meetings of committees, the infinite details of innumerable discussions fade into nothingness as the curtain rises on a new chapter in our Association's history. The wish, the dream, toward the realization of which so much effort has been expended, is at last a thrilling reality.

November 12, 1958 will be recorded in the annals of the Alberta Association of Registered Nurses, and in the hearts of its thousands of members, as the day when a dream came true. Then it was that the splendid new three-story building at 10256-112th Street, Edmonton, was declared officially open. Then it was that Miss Margaret M. Street, President, assisted by other officers of the Association, conducted appropriate ceremonies in the presence of representatives of the provincial and civic governments, the University of Alberta, the Canadian Medical Association (Alberta Division), the Associated Hospitals of Alberta, and nurses from all over the province. It was a proud moment for one of the charter members of 1916, Miss Lottie Hunter, when she unveiled the bronze plaque: "Dedicated to Our Professional Heritage and to Continuing Growth Through Service." This plaque is now proudly viewed by all members who enter the reception area. Seventh of the provincial associations to own their administrative headquarters, third to have constructed their own building, the nurses of Alberta are proud of the fact that this

(David Miller—Edmonton)

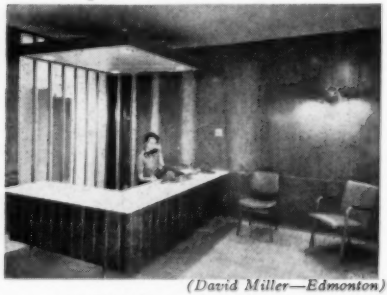
Officially Open

entire project, valued at approximately $100,000, has been financed through the gradual accumulation and careful husbanding of the Association's funds.

Designed by Mr. Nicholas Flak and erected by Murmac Construction Limited, the building consists of three floors and is as practical and feminine as the modern nurse herself. It features a basic DU-AL block structure and attractive curtain wall construction with brick facing at the front exterior. The wall facing of baked pastel blue enamel on aluminum, with a touch of soft lemon yellow above the blue and silver entrance canopy, means there won't be any expenditures for paint repair jobs. The double-glazed glass windows assure warmth in winter and plenty of sunshine to accentuate the bright, cheerful atmosphere inside. In summer, with the tightly-sealed double-glaze, the reverse effect is achieved.

All the windows are draped in crisp "Terylene" material, a decorative note as pleasing from the outside as it is in the interior.

Entering through the glass doors, a few steps lead up to the main floor and reception area. A small, recessed



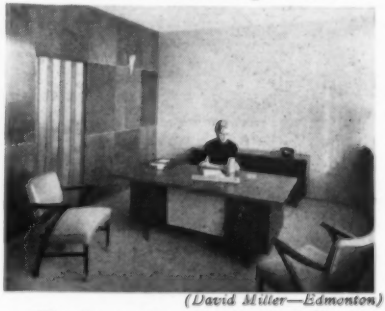
(David Miller—Edmonton)

The Reception Area

planter in the white arborite-topped desk, adds a cheerful spot of color to the area where the receptionist works under a well-lighted canopy. The hues throughout are soft sandalwood alternating with turquoise.

Immediately across from the reception area is a waiting room with a louvred panel separating it from the general office. This use of louvred panelling gives an air of spaciousness to the office. A sette and armchairs, comfortably proportioned to the limited space, contribute to the pleasure of visitors who may choose to sample the magazines on the table.

The sunshine that streams in the windows isn't any more cheery than the cooperative-minded staff who work in the general office under conditions approaching the ideal. The desk area has been so designed that it provides the most efficient tools to do the job that has to be done. Beyond the general office is another compact working space devoted to the accounting duties.



(David Miller—Edmonton)

The Executive Director's Office

The executive director's office at the front of the building is designed with an eye to simplicity and function. Dominating the room is the overhung walnut desk made up in the modulaire style. A wall unit immediately back of the desk chair consists of a series of shelves, drawers, and filing space, all enclosed in panels with arborite legs in bronze-toned brass. The simply curtained glass-panelled east wall permits the maximum of light. This office affords the luxury of a synthetic Trilan Treebark rug in soft beige. With a small chesterfield settee, the room is sufficiently large to be used as a small conference area. An accordion-type door in the mahogany-panelled walls opens on a commodious clothes closet. As in all of the newer type of executive offices, a small washroom with sink and toilet in seafoam green, completes this accommodation.

Framed by spacious windows at the rear of the building is the office of the registrar. Instead of four square walls, a much more pleasing effect is achieved with a thirty degree angled wall separating the registrar's office from the adjoining office, which will be occupied by the Nurses' Community Service staff. It it just another of those innovations that lends a distinctive air to the nurses' new building. Similar type walls are featured in other offices,

including the downstairs lounge.

A general purpose room at the back of the building houses the mechanical equipment, such as addressograph, etc. Another small area is devoted to the business of sorting mail.

In addition to the girls' modest, streamlined powder room, there is a staff cloak room and additional toilet and washroom facilities for male and female visitors as well as a janitor's utility room.

On the first floor, just below ground level, the stairs lead directly to the cloak room, a sensibly-sized space where one may sit down and remove outside winter footwear. Equipped with coat-hangers on either side, provision is also made to take care of gentlemen's hats.

To the right of the stairway is the lounge. One wall is panelled in rotary-cut mahogany veneer in suntan finish. Underneath the glassed east wall, eight custom-built seats are to be finished in turquoise and white to match the smart Kroehler sofa-bed of nylon and fabrilite fabric.

Across the hall is the board room where the mahogany finish is contrasted with a knotty cedar panelled wall. This room, which will be equipped with close to 100 stacking armchairs, finished in plastic Fabrolite, will be available for board meetings, conferences, as well as social events. It lends itself admirably to buffet service when a social event is scheduled. A blackboard and movie screen is yet to be installed opposite the windowed wall. When not in use they will be concealed by Flite-Deck turquoise drapes.

A well-appointed kitchen in natural mahogany finish is equipped with an electric stove as well as ample refrigerator and cupboard space. Leading off from it is the lunch room, very modestly equipped with a chrome dining suite.

Across the hallway from the lunchroom is the library, furnished in substantial oak pieces.

A storage vault, stationery and furnace room, washroom and janitor facilities occupy the balance of the space on the lower floor.

With an eye to a source of revenue to help complete the payments on the building, a third floor, comprising some 2800 feet, was added. Divided into spacious quarters, equipped with washrooms and janitor space, they will make ideal office accommodation for some lucky tenants.

Each floor is individually heated and air-conditioned, with access to front and back stairs.

A large parking space will accommodate cars of staff, tenants and visitors.

Bricks, mortar, steel and glass are inanimate objects until they have been translated into working areas. With this thought in mind, and the A.A.R.N.'s record of achievement in making this building a reality, we believe the new Provincial Office of the Alberta Association of Registered Nurses will be a place where dreams do come true.

CLARA VAN DUSEN
Executive Director

The convener of the program committee might find it helpful to consider these points as she and her committee members plan activities for the organization.

1. Are you bringing more members into active participation? The responsibility for planning the program should not fall on the same old faithfuls every year.
2. Do your programs help the members in their work? You will want to make certain that there is something to appeal to nurses in all types of positions and specialties represented in your section.
3. Do you make a point of avoiding the "same old thing" every year? Too predictable a pattern can kill interest.
4. Do you have specific short-term goals? Some groups may find it worthwhile to choose a particular theme for one year's emphasis.
5. Do your members know your calendar of forthcoming events? This may help to increase the size of your meetings. Planning the full year can help your budget committee.
6. How many meetings should you hold? No matter how large or small your community, people are going to be busy. Schedule only as many events as can be handled well.

— *American Journal of Nursing*

Gastrointestinal Intubation

W. Grobin, M.D.

Gastric intubation has been practised for well over 150 years. Dr. Physick, of Philadelphia, is known to have been the first on this continent to pass a tube into the stomach for medical purposes. That was in 1812. Since that time many procedures of intubation have been developed. Each in turn had its adherents for a while. Most of them are not in use any more since the modern methods of x-ray examination have brought much greater accuracy to the diagnosis of diseases of the gastrointestinal tract. In spite of these advances, however, and in some cases *because* of them, some procedures of intubation are coming back into use more and more. The following are still being used almost universally:

1. *Gastric analysis* — for diagnosis only:

(a) Fractional with CHO meal — Rehfuss method
(b) Insulin test
(c) Histamine
(d) Caffeine

2. *Duodenal drainage* — mainly for diagnostic, but sometimes for treatment purposes.

3. *Miller Abbott tube* — mainly for treatment; also for diagnosis in conjunction with x-ray.

4. *Wangensteen tube* — treatment purposes.

5. *Gastric lavage* — mainly as a treatment but has some diagnostic value.

More elaborate procedures, based on the above, are used in research laboratories to study the gastrointestinal tract. There are the double and triple lumen and balloon tubes that enable one to remove gastric juice from one area without admixture from above. The double balloon tube is now used with increasing frequency to arrest bleeding from esophageal or gastric varices.

It is the writer's impression that some of these procedures, although ordered routinely by most doctors and carried out on the wards of most hospitals as a matter of course, are usually unsatisfactory and the results obtained unreliable. This particularly applies to gastric analysis.

The writer may be forgiven if he feels rather strongly on this subject. Having himself passed many tubes into the stomach and the duodenum, he knows how easily it can be accomplished if an expert does it. On the other hand, the inexperienced can reduce a patient to tears and cause an uproar because the patient "could not swallow the tube." Admittedly, the instances of complete inability to pass the tube are rather rare. The percentage of cases in which excessive gagging takes place during the act of swallowing, and even later throughout the procedure, is undoubtedly high. Gagging causes a reflux of bile into the stomach. At the same time more saliva is being swallowed than would ordinarily be permitted to happen. Both of these juices dilute the gastric contents and alter their composition to such an extent that the results of the tests are largely rendered valueless.

The fractional gastric analysis with a carbohydrate meal as a stimulant is generally considered as the best method of examining the total work of the stomach. It includes both its motor work and its secretions. The motor work is gauged by measuring the amount of bread left in the samples of juice aspirated throughout the test. Fast disappearance means overactivity; large amounts of bread in the last sample — delayed emptying. If recorded on a chart designed for the purpose, this information can be useful. The degree to which the bread has been chymified is also of interest. Other facts that emerge are the amount of fasting juice, its appearance, the presence of abnormal constituents, such as food from the day before, pus, (swallowed pus will be mixed with mucus, bile-stained pus will point to the duodenum), malignant cells, blood (if only present in the samples which are bile-

Dr. Grobin, formerly of St. John's, Newfoundland, is practising in Toronto.

stained, it points to the duodenum). Lactic acid indicates gastric retention.

The degree of free and total acidity in the fasting as well as the fractional samples can be estimated. Each one of these findings has its significance, and the total information can be of great help especially in cases where the x-ray investigation has failed to provide a clear diagnosis. In other cases it will help to form an idea about the course of treatment that should be followed and the chance that medical treatment will or will not be successful.

The majority of doctors order gastric analysis as part of the routine of a gastrointestinal investigation. They tend to glance only briefly at the acidity curve and perhaps at the presence of lactic acid and malignant cells if this examination was done. The finding of occult blood is usually ignored because it is suspected to be due to trauma during aspiration of gastric juice. This suspicion is unfortunately justified. Low acid findings, if they do not fit one's expectations in a given case, make one suspect that the tube had been allowed to pass into the duodenum, or had not been passed into the stomach at all, but had remained in the lower esophagus. The aspirate is in reality, saliva. Again, experience has taught us that such suspicions are justified. In order to obtain correct readings of free and total acid, the samples should be tested as soon as possible after extraction. Some hospitals have not the facilities for titration. All the samples are collected and then sent to a central laboratory, arriving there perhaps one or two hours later. This will undoubtedly alter the actual acidity levels.

These are just a few of the pitfalls which seriously diminish the value of this otherwise excellent test.

In the case of the histamine test, the situation is somewhat simpler, but it also has its pitfalls. Its main use is to establish whether the patient has an absolute achlorhydria — that even after an injection of a potent preparation of histamine, his stomach is unable to secrete hydrochloric acid. This helps in the diagnosis of pernicious anemia, in particular. If the histamine is inactive, or if the tube is not in the stomach, the results will be useless. On the other hand, if the fasting specimen contains free acid, it is unnecessary to proceed with the test. Achlorhydria has been ruled out.

The insulin test is based on the fact that the stomach secretes hydrochloric acid if the individual has been given enough insulin to lower his blood sugar to hypoglycemic levels. This reaction takes place if the vagus nerves to the stomach are intact. After vagotomy this test has some value in estimating how thoroughly the surgeons have been able to disrupt the vagal nerves to the stomach. If, after an adequate dose of insulin, the sugar has been depressed to, say, 0.50 mg.% and the gastric juice samples during the following hour fail to show a rise in free hydrochloric acid, one can assume that vagotomy was satisfactory.

The caffeine test has been used in some places instead of the carbohydrate meal. It is claimed that when high acidity curves are obtained after stimulation with caffeine, it indicates duodenal ulcer or potential duodenal ulcer.

Duodenal drainage was developed by Lyons, of Philadelphia, in the 1920's. It was used primarily for diagnosis of diseases of the biliary tract. Lyons claimed great successes from its use as a treatment of early infections of the gallbladder. Duodenal drainage enjoyed great popularity in the 1930's and early 1940's, especially in European medical centres. As the x-ray examination of the biliary tract became more efficient, interest in duodenal drainage naturally decreased. Many present-day doctors and nurses have never even seen it performed. As a method of treatment, it has never been accepted without challenge, though there are still some clinicians who report its use in certain conditions, such as the obstructive phase of infectious hepatitis. The writer has used this "non-surgical drainage of the galltract" in a few such cases with undoubted benefit.

The main value of duodenal drainage is in the diagnosis of diseases of the duodenum, biliary tract and pancreas. During recent years it has been used mainly in the research laboratories for the study of pancreatic function. The tip of the tube is guided into the second part of the duodenum under fluoroscopic control. An injec-

tion of Secretin is given, which acts as a stimulus to the pancreas. The volume, chemical and cytological composition of the juice obtained is then studied. An injection of magnesium sulphate through the tube relaxes the sphincter of Oddi and permits bile from the gallbladder and from the liver to reach the duodenum and thus to be aspirated. The bile so obtained can be examined for abnormal constituents. It can be cultured and its chemical composition studied.

Cholesterol crystals are good evidence of stones in the biliary tract; blood or pus, especially if bile-stained, has great diagnostic significance. Malignant cells may be found in the duodenal juice. If, after repeated injections of magnesium sulphate, no bile can be obtained and the same failure to obtain bile is verified by a second duodenal drainage, obstruction of the common duct is almost a certainty. In clinical practice this examination becomes particularly useful when x-ray examination of the biliary ways is unsatisfactory or impossible, as, for example, in many cases of severe jaundice.

Little need be said about the use of the Miller-Abbott tube in the treatment of bowel obstruction. Thanks to the cooperation of the radiologists, this method has become very successful and has permitted the surgeons to wait until the patient is in good shape for operation. By injecting a small amount of barium through the tube, the site and nature of the obstructing lesion can be determined. In cases of paralytic ileus, the Miller-Abbott tube enables us to carry on with intravenous replacement therapy until the bowel has recovered normal function once again.

Both the Wangensteen tube and gastric lavage are used mainly for treatment. Preoperative and postoperative management of patients has greatly improved thanks to the judicious use of the Wangensteen tube. It is of great value in cases of paralytic ileus if for some reason a Miller-Abbott tube cannot be passed. The rationale of its use in this condition is that most of the air found in the bowel is swallowed air. Acute dilatation of the stomach is another very important condition in which both the Wangensteen tube and lavage are of great value. One must not forget, however, that tubercle bacilli and malignant cells can be recovered from gastric contents by special techniques.

Finally, the indwelling tube used mainly for tube feeding has to be mentioned. It, too, finds a place in diagnosis. Overnight collection of gastric juice is being used in many centres as a method of study as well as for the proper evaluation of the ulcer patient. Night secretion is considered to be of great importance in the production and persistence of peptic ulcer. Continuous neutralization by indwelling tube with antacids had its vogue some ten years ago and still has its use in the refractory case of peptic ulcer.

As mentioned under gastric analysis, the success of all these procedures depends on careful attention to detail. Though essentially medical, they have to be standardized in the same way as surgical procedures. A routine has to be followed in each case, and yet there must be an experienced person supervising the crucial stages of each procedure. He may order a change in routine, if necessary, or discontinue the procedure altogether if conditions so require. Nobody can claim that intubation is a pleasant procedure. Many patients dread the thought of a tube. Patients with digestive disorders have, for obvious reasons, difficulty in swallowing tubes. The experienced technician can greatly facilitate the process of swallowing. This is especially important because not infrequently intubation has to be repeated.

After many years observing the unsatisfactory results of gastroduodenal intubation in general and that of fractional gastric analysis in particular, the writer is of the opinion that intubation should be considered as a specialty and be placed under the direction of a nurse or technician with special training and interest in this field. This person could then in turn train others, so that the hospital would be sure to have at all times somebody available who is well versed in the proper technique of gastroduodenal intubation for therapeutic as well as diagnostic purposes.

* * *

I am a man, and nothing that concerns a man do I deem a matter of indifference to me. — TERENCE

Duodenal Ulcer

HELEN LEMIEUX

MR. BAKER, 65 YEARS OLD, well educated, intelligent, had recently retired from an executive position with a national firm after a useful, busy life. A father, and grandfather, he was obviously devoted to his seven children and their families. These ties plus an avid interest in music and photography had helped him adjust to his retirement from a more active life. He was admitted to hospital for treatment of a recurrent ulcer.

MEDICAL BACKGROUND

Physicians have for years argued about the relationship between worry and excitability and the so-called ulcer patient. It is believed by many that there is a definite tendency towards the condition in the person who possesses these characteristics. Ulcers occur more often in males between the ages of 20 and 40 and seem to favor the spring and fall seasons.

MEDICAL HISTORY

A peptic ulcer is an excavation found in the mucosal wall of the duodenum, the stomach, or the distal esophagus and is due to the erosion of a circumscribed area of its mucous membrane. The etiology is poorly understood, but it seems to develop in persons who are emotionally tense; however whether this is the cause or effect of the condition is uncertain.

Mr. Baker had been in hospital five years previously for treatment of an active peptic ulcer. He recovered well from it and was discharged after a brief stay. A year later he was readmitted for removal of an enlarged prostate gland. The operation apparently left no ill effects. It might also be well to mention that he suffered from hypertension and was periodically treated for this condition. He had a coronary thrombosis several years ago, but apparently had recovered rather well from it, as he was quite active and had no handicap. A superficial phlebitis of the left leg was also revealed through his history. This left no ill effects. For four days prior to this admission, Mr. Baker had been passing tarry stools. He had also felt extremely weak but had no acute pain in the abdomen or other regions. On the evening of his admission, he had a massive hemorrhage from the bowel. This prompted him to call his physician.

On admission Mr. Baker's face was noticeably pale, he was extremely weak but very alert, and he looked worried. A blood pressure of 118/78 on admission revealed loss of blood. Mr. Baker was very apprehensive. Special care and patience were necessary to put him at ease and ensure proper understanding of and cooperation in the treatments he would receive. This apprehensiveness was partly due to the fact that he was suffering from a temporary anemic condition due to loss of blood. It seemed probable that Mr. Baker was suffering from a bleeding duodenal ulcer.

Although he was not in pain at the moment, there seemed to be some tenderness in the left lower quadrant upon palpation. The pain, characteristic of this condition, is a dull burning one which usually occurs from two to four hours after a meal and is usually relieved by an alkaline or milk. Other symptoms typical of ulcer are exhibited, one of which is vomiting. This is usually due to pyloric obstruction, either muscular spasm of the pylorus, or mechanical obstruction. Mr. Baker frequently vomited a dark "coffee-grounds" emesis. This was probably due to destruction of the mucous membrane of the stomach with some blood and vessel destruction. Hemorrhage is sometimes found in the ulcer patient, although this is considered a complication rather than a symptom. Tarry black stools show evidence of hemor-

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Miss Lemieux wrote this nursing care study while she was a junior student at St. Mary's Hospital, Montreal.

rhage and frequently fresh blood is also found upon defecation. The blood loss explained why Mr. Baker's hemoglobin was 6.7 gm. per 100 cc. on admission instead of a normal 12.0.

The diagnosis was gastrointestinal hemorrhage due to a bleeding duodenal ulcer.

An x-ray revealed that the esophagus was normal, as was the stomach whose curvatures were well-defined and whose mucosal pattern was well-preserved. The pylorus was patent. However the duodenal cap was deformed by deep indentations on its greater curvature, and in the center a large barium spot was present. The duodenal ring was not enlarged, but evidence of a large diverticulum on the medial aspect of the second duodenal portion was noted. This confirmed the original diagnosis of bleeding duodenal ulcer.

Urinalysis was essentially normal.

A chest x-ray is usually routine in order to detect any serious chest deformity or lung disease, in particular tuberculosis. It revealed an elevation of the right diaphragm, that had been noted during a previous examination in 1954. However, it further revealed a horizontal density immediately above the upper limit of the dome of the right diaphragm probably due to a pleural effusion of recent development.

Therapy and Nursing Care

Mr. Baker's anemia from the hemorrhage was corrected by blood transfusions. He was kept on complete bed rest to prevent excessive bleeding and to help heal the ulcer. Blood pressure readings every four hours were used to detect possible shock.

The main medical treatment of a bleeding peptic ulcer is diet. Mr. Baker was treated medically for approximately two weeks. Diet therapy consisted of giving him no solid food, but frequent feedings of milk and cream. This protected the ulcer from exposure to gastric juice by neutralization. They are bland and non-irritating. Feedings are given in frequent small amounts so that the stomach at no time is overloaded, and severe peristalsis is prevented.

Medication also plays an important role in the treatment of ulcer.

Atropine is a drug derived from the plant Atropa belladonna. It is anticholinergic — that is, it blocks the action of acetylcholine. By blocking this chemical, which is normally released when the parasympathetic nervous system is stimulated, the vagus nerve is depressed. In turn, gastric secretions are lessened as well as gastric motility. The drug is given gr. 1/150 t.i.d. and at h.s.

Amphojel is an antacid. It lowers the acidity of the gastric content, mainly by neutralizing the excessive stomach secretion of hydrochloric acid. It may be given in doses of two drams every hour.

Premarin 20 mgm., was ordered in this instance to be given directly into the blood stream with the intravenous fluids, to help control excessive hemorrhage. It is a synthetic drug composed of conjugated estrogenic hormones.

Phenobarbital was also given. It has a long-acting sedative and hypnotic effect on the body, promoting muscle relaxation. It was ordered gr. ¼ t.i.d. and at h.s.

Morphine helped to keep the patient sedated. It is a derivative of opium and is commonly used as a central nervous system depressant. It was given in doses of gr. ¼, immediately following admission.

Chloralol was also given. It is a member of the chlorinated hypnotic group. Its action depresses the cerebrum and spinal reflexes, and produces sleep. Grains 10 was given at h.s.

Potassium chloride was added to each intravenous injection of glucose and saline solution to ensure electrolyte balance. It was given both preoperatively and postoperatively.

Vitamins B and C were a necessity both before and after operation, because Mr. Baker had not been eating.

Mr. Baker's heart function was not adequate. This was noticed by some distention in the neck veins due to blood backing up into the inferior vena cava from the heart. For this reason, he was digitalized. A patient is said to be "digitalized" when the optimum cardiac effects from the drug have been reached. Mr. Baker was given 0.5 mg. of Digoxin b.i.d. for two days until he was digitalized, then a maintenance dose of 0.25 mg. b.i.d. was ordered. Digoxin is a purified substance extracted from the leaves of white foxglove. These sub-

stances act on the heart muscle itself strengthening its contractions and improving the output. This, in turn, relieves pulmonary edema and poor circulation. It is important to take the patient's pulse before administering the drug. It should be withheld if the pulse is lower than 60.

Seconal 1½ grains was ordered when the patient required a hypnotic after h.s. Seconal belongs to the barbiturate family, is short acting and produces a restful sleep.

Mr. Baker's intake and output were noted to check his electrolyte balance and to detect any cardiac deficiency resulting in edema. His general health had to be improved so that surgery could be performed. Blood transfusions were continued until his hemoglobin was normal.

He presented some nursing problems during this period. He was restless, apprehensive, worried and nauseated. The latter was especially distressing to him. He felt he would never get well unless he could reach a satisfactory nutritional state. His nausea seemed to last up to about one hour after his feedings, and he often vomited half digested milk with fresh clots of blood. For this reason he was finally left at complete rest following his feedings and if he vomited, a second feeding was attempted after a half hour, usually with success.

Mr. Baker's stool became free of visible blood and for three days specimens for occult blood were collected. Examination showed that his stools were completely free of blood and it was at this point that surgery was decided upon.

It is a hard task to determine which ulcer patient will benefit from surgery and which one will not. It is certainly not considered a cure for the condition. The old statement of "once an ulcer patient, always an ulcer patient" seems to prove true in many cases. Surgery is often performed when the patient is over 50 years of age and when severe hemorrhage has occurred more than once. Subsequent hemorrhage might become uncontrollable and eventually prove fatal in older persons since their physical state is already on the decline.

Mr. Baker seemed very happy about the surgeon's decision and confided that he felt something was at last going to be done about his condition.

Specific orders were written for further tests. An electrocardiogram, requested because of the patient's known heart condition, revealed an increasing left ventricular ischemia that would certainly be important to the surgeon and anesthetist during and immediately following the operation.

Intravenous therapy, consisting of glucose and water and glucose and saline was started about three days before the operation in order to keep up Mr. Baker's electrolyte balance, to prevent dehydration and build up his general health. Several blood transfusions were given also. Intake and output were recorded throughout this period.

Spiritual and psychological preparation is very important. It was explained to Mr. Baker that although part of his stomach would be excised, he would still be able to eat, although moderately at first. The remaining portion of his stomach would enlarge somewhat and his nutritional needs would be met very easily. It was also important to tell the patient that he might feel uncomfortable after the operation and that a tube would be inserted for a while. A visit from the clergyman may also help to put the patient at ease.

The Operation

A major shave preparation was done on the preceding day. It consisted of shaving the patient from the nipple line down to six inches on each leg, and on either side from bedline to bedline. A soap suds enema was given in order to empty the colon before surgery.

Sedation, consisting of seconal gr. 1½ was given at bedtime to ensure as restful a sleep as possible.

In the morning a Levine tube was inserted. This tube, which was passed through the nasopharynx down through the esophagus into the stomach, drains off the gastric juices and prevents postoperative nausea, vomiting and gastric distention.

A second skin preparation was done in the morning. This consisted of painting the shaven area with ether, then alcohol and finally iodine. The preoperative medication consisted of Demerol 100 mgm. and atropine, gr. 1/150. Mr. Baker's blood pressure was 170/

110 and temperature, pulse and respirations normal prior to operation.

The abdomen was entered through a right paramedian incision and a partial gastrectomy performed. This consisted of removing the ulcerated area in the duodenum and ⅔ to ¾ of the stomach. An end to end anastomosis was made between the end of the stomach and the jejunum. A cigarette drain was inserted into the duodenal stump to drain any discharge to the exterior and to prevent leakage through the duodenal suture into the peritoneal cavity.

Postoperative Nursing Care

Mr. Baker was brought down from the operating room at 2:00 P.M. and placed in a quiet ward on surgery. A nurse remained with him for the next hour. He was pale, conscious and drowsy. Nasal oxygen was started at 2:15 P.M. and continued for six hours. At 2:30 P.M. he complained of pain in the operative area and demerol was given "stat." Demerol had been ordered q.4 h. p.r.n. for 48 hours to relieve pain. Meperidine HCl (Demerol), is one of the synthetic substitutes for morphine. It is not a potent drug but has a distinct capacity to cause addiction. Its analgesic effect in man is slightly stronger than codeine and lasts for 2 to 6 hours. It is most effective in relieving postoperative pain.

Blood pressure and pulse readings were ordered q.15 m. for two hours then every half hour until stable. It was 140/110 on return from the operating room and remained fairly stable throughout the day, rising to 160/120 in the late evening. A small area of bright red blood on the outer dressings was noticed at 3:00 P.M. At 3:30 P.M. Mr. Baker was visited by the anesthetist and appeared to be responding satisfactorily although very drowsily.

An intravenous of 5% glucose and water that had been started in the O.R. was checked and appeared to be running well. The Wangensteen suction was draining thick, dark reddish fluid. At 4:30 P.M. the patient was again visited by the anesthetist. He was perspiring freely and his bed linen was changed frequently to keep him comfortable. The Levine tube was irrigated frequently all day to ensure proper drainage. A sponge bath was given to lower Mr. Baker's temperature which was elevated to 101°. Back care was given to prevent the development of pressure areas. Changing his position every two hours was also helpful.

Deep breathing exercises are very important in the prevention of hypostatic pneumonia and Mr. Baker was encouraged to do them. He was also encouraged to cough frequently while his suture line was held by the nurse. At 8:00 P.M. the nasal oxygen was discontinued since Mr. Baker's breathing was greatly improved. Mouth care was given q.3 h. throughout the day. At 10:30 P.M. Mr. Baker felt very distended and voided 480 cc.

Alevaire inhalations were given twice daily for four days to ensure a clear passageway into the lungs and prevent accumulation of mucus that might lead to pneumonia.

Intravenous therapy postoperatively prevented dehydration. Glucose and water 1000 cc. was alternated with 1000 cc. of glucose and saline. The intravenous therapy was continued for three days. Mr. Baker received 1000 cc. the first day, 2500 cc. the second day, and 3000 cc. on the third and fourth days. Wydase, an enzyme, was added to help absorption.

After the first 48 hours, Demerol was replaced by aspirin phenacetin compound with codeine to prevent addiction or even a psychic dependence on the drug. A preparation of penicillin and streptomycin (Fortimycin) was given twice daily for five days prophylactically. Iron, in the form of ferrous gluconate was given t.i.d. after meals. It was used to combat the anemia due to hemorrhage.

Nothing was given by mouth immediately postoperatively, and only sips of water on the second day. Mr. Baker followed the special gastrectomy diet. On the third day, he was given one ounce of milk alternating with one ounce of water every hour. The fourth day junket, ice cream, jello, milk and water were added. The clysis was decreased to 1000 cc. On the fifth day, no intravenous was given. Fluids were taken ad lib., with additional pureed food and soft eggs. Mr. Baker tolerat-

ed all of this food very well.

His diet was kept at this level until the twelfth postoperative day when a bland No. 2 diet was substituted. His meals, apart from what he had been taking, consisted of cottage cheese, mashed potatoes, minced meat, white chicken, white fish and melba toast. This was continued throughout his stay, and was changed to a bland No. 3 diet when he was discharged.

On the fourth postoperative day, Mr. Baker's Levine tube was clamped. He was carefully watched all that day for nausea and vomiting. By evening, he had shown no signs of distress, and the tube was taken out completely. His drain was shortened then removed on the following day.

The fifth day after his operation the patient was allowed up in a chair for 15 minutes. No ill effects were noted and each day thereafter, Mr. Baker although still quite weak and not too sure of himself, spent some time out of bed.

On the 12th day, most of the small black silk sutures were removed. The incision appeared clean, but at the site of the third stay suture, a reddened area was noted and a slight purulent discharge seemed to be seeping out. Magnesium sulphate with glycerine compresses were applied to the inflamed area, in an attempt to halt the process. This was not effectual. On the 14th day Mr. Baker had a fainting spell while in the chair and was immediately put on complete bed rest with blood pressure readings every half hour for two hours. The following day, the remaining stay sutures were removed. The discharge was still purulent and copious in amount. A culture and sensitivity test were ordered. The results showed a heavy growth of *Staphylococcus pyogenes* and measures were immediately taken to control this infection and prevent its spread. Mr. Baker seemed perturbed about the whole thing. His mind was set at ease by an explanation and the assurance that treatment would be successful.

A small incision was made and one inch packing inserted. The purulent discharge became greenish and continued in large amounts. Hot compresses were applied q.3 h. and a hot water bottle continuously. A few days later, when the discharge still continued, irrigations with saline were ordered and carried out three times a day with very good results.

Health Teaching

Essentially Mr. Baker has taken good care of his health. His personal hygiene was good. It was important to try to help him to relax and to discuss his difficulties.

Mr. Baker was anxious to cooperate with the doctor and nurse. He sincerely believed that they had done an essentially curative treatment by removing the afflicted organ. He was discharged on a bland No. 3 diet. This consisted of a nearly normal diet based on milk. It was explained to him that he must take approximately six glasses of milk per day, eat cottage cheese often, and avoid spices, broth, roughage and bulk. His wife was told that he should have simple cooking, no fried foods, tender meats often and two eggs daily. She was anxious to comply with this as she had seen a definite improvement in her husband and wished to help in whatever way she could.

Mr. Baker was given one month's supply of digoxin 0.25 mgm., and both he and his wife were instructed that he must take two doses daily. Finally, he was advised to revisit his doctor frequently at first and to have periodic medical check-ups later.

The apparent self-liquefaction of clotted blood and auto-digestion of necrotic tissue are age-old clinical observations . . . Recent studies indicate that clotted blood is digested by the proteolytic enzymes present in the blood and that necrotic tissue is digested by enzymes produced by bacteria, leukocytes and body tissues.

When the proteolytic enzymes are applied locally to an infected wound or abscess, they digest the complex proteins and pus to decrease the viscosity of the material. The degree of phagocytosis is increased and pus can be removed from the wound more easily. The changes produced by the enzymes thus initiate a series of biochemical changes leading to healing.

— *American Journal of Nursing*

Peptic Ulcer

CAROLE ELDRIDGE

THE CONDITION

A PEPTIC ULCER is an excavation in the mucosal wall of the stomach, the distal esophagus or the duodenum that may extend to the muscle layer, or even to the peritoneum. Most ulcers, whether gastric or duodenal, are found near the pyloric sphincter of the stomach, and usually appear singly, although more than one may be present at a time.

Peptic ulcers belong to a group of psychosomatic conditions. Their exciting cause is unknown, but is probably due to the digestive action of gastric juice on a part of the stomach whose nutrition has been impaired by a local circulatory disturbance. Contributing factors include poor eating habits, excessive smoking, emotional tension, worry, and other mental stress. Worriers, excitable types, and persons who are emotionally tense but have a calm exterior, are all prone to digestive ulcers. Statistical studies have shown that certain occupations which involve a great deal of mental stress and tension predispose to the development of peptic ulcers, and "there is much to suggest that the increase in duodenal ulcers may be due to the increase in the stresses and strains of modern life."

An ulcer may remain latent for an indefinite period and later be announced by hemorrhage or perforation, but generally symptoms of dyspepsia, epigastric pain and tenderness, nausea, vomiting and hyperchlorhydria, occur.

Complications that may result from a peptic ulcer are: perforation and peritonitis, hemorrhage, edema or scar formation that may obstruct the pyloric sphincter.

The prognosis of a patient with a peptic ulcer is guardedly favorable. Hemorrhage or perforation may occur without warning, and relapses with the formation of new ulcers are not uncommon. To prevent recurrence the patient must be taught to avoid stress situations, use good eating habits, follow his prescribed diet, avoid the use of alcohol and tobacco, get adequate rest and exercise, practise good hygiene. A medical examination at least once a year, and early reporting of symptoms if they return are essentials that must not be forgotten if this condition is to be controlled.

Miss Elridge will graduate this year from Royal Columbian Hospital, New Westminster, B.C.

THE PATIENT

Mr. Carter, the youngest of 10 children, was born in Birmingham, England in 1893. Most of his formal education was gained there while he went to public school, served an apprenticeship, and later attended technical school to study mechanical engineering.

In 1914 he came to Canada where he spent the next eight years living in the Northwest Territories while serving as an R.C.M.P. officer, and later as an employee of the Hudson's Bay Co. Although Mr. Carter has been in all the Canadian provinces, British Columbia has remained his favorite. He has lived there for the past 29 years. For this length of time he has been employed as a machine shop instructor in the provincial penitentiary.

Recreational activities include reading and short story writing. He derives much enjoyment out of his affiliation with a men's club. Mr. Carter has led a very interesting life which contained its share of tragedy, as well as joy. His first wife, whom he married before leaving England, was killed in a railroad accident and his second wife died in a fire. Later he remarried, and now has a son, daughter, and six grandchildren of whom he is very proud.

Mr. Carter is a large man who stands five feet eleven inches tall, and weighs 230 pounds. He seems to have an above average intelligence. Outwardly, he is very calm and complacent, always cheerful, willing and cooperative. He mixes well with the other patients, and adjusts himself easily to the ward and hospital life. His relationships with other patients give him much pleasure. It

was a real joy to care for him.

Past History

Except for a case of recurrent lumbago Mr. Carter had been in excellent health until 1953 when he was admitted to the hospital in severe shock with a diagnosis of gastric hemorrhage, and a history of hematemesis and melena. After extensive examinations he was discovered to be suffering from a duodenal ulcer. Following treatment that included blood transfusions, other intravenous therapy, drug therapy, and diet regulation Mr. Carter made a satisfactory recovery.

He was released from hospital at the end of three weeks for further convalescence at home. On the advice of his doctor, he refrained from the use of alcohol and tobacco. He began to realize that emotional disturbances caused him distress, and he tried to avoid them whenever possible. For a period of time Mr. Carter adhered to his diet and its restrictions, then, due either to lack of understanding of the importance of diet in ulcer healing, inadequate teaching or sheer neglect, he became very lax about it, and still later made no attempt at diet control.

In early 1955 Mr. Carter spent several weeks in bed at home while being treated for angina pectoris and persistent hypertension. His usual blood pressure was 200/110. At this time attempts were made to reduce his weight, but they failed. About six months before his second admission to hospital Mr. Carter began to experience gastric distress and a few months later, because of its persistence, he again visited his doctor. Following a barium meal, stomach and duodenal x-rays were taken, and revealed that the original duodenal ulcer was still present and unhealed. A gastric ulcer had appeared on the lesser curvature of the stomach near the pyloric sphincter. He was again placed on medical treatment in an attempt to control his symptoms, and appeared to do fairly well.

Present Illness

A couple of years later, Mr. Carter was admitted to the emergency ward in acute shock following a severe hematemesis. He was very pale and diaphoretic, B.P. 170/100, pulse rapid and thready. He complained of epigastric tenderness. Physical examination revealed that eyes, ears, nose, throat and glands were normal. Heart sounds and respirations were normal, and chest sounds were clear. Questioning at this time revealed the presence of melena for about two weeks, but apparently the patient did not realize the significance.

For six to eight weeks previous to this admission, Mr. Carter had been experiencing dull, aching epigastric pain approximately two hours after supper. It usually lasted two to three hours, and some relief was gained by the use of aspirin and a hot water bottle applied to the upper abdomen. Later it was found that bismuth preparations and milk of magnesia would bring about some relief. There seems to have been little or no attempt on the part of the patient to prevent and control pain by diet. Dyspepsia, found commonly in ulcer patients, was not one of Mr. Carter's symptoms. He could and did eat anything. He found that when he got excited, worried, or "mad," epigastric discomfort would result. This is a typical ulcer symptom.

Vomiting, the second classic symptom of a peptic ulcer, was absent in Mr. Carter's history until 30 minutes previous to this admission.

Hemorrhage, as manifested by hematemesis and melena was present in Mr. Carter's case, as it is in about 25% of all ulcer patients. For about two weeks prior to admission he had been passing black stools, and on the night of admission was nauseated, with a "coffee-grounds" emesis that revealed the presence of blood in the stomach for some time. Following this there was an emesis of bright red blood which indicated the presence of a frank hemorrhage in the upper gastrointestinal tract. After this unusual occurrence Mr. Carter's family rushed him to the hospital.

Laboratory Reports

Hematocrit	*normal*
1st day 40.5%	45%
2nd day 45 %	
3rd day 43.5%	

The first hematocrit estimation was low because the blood had been thinned by body fluids. Following transfusion with 2000 cc. whole blood it returned to normal. After the transfusions ceased more body fluids entered the circulation and thinned the blood slightly

so the number of red cells in each cc. of circulating blood was slightly below normal.

Hemoglobin			*normal*
1st day	A.M.	14.6 Gm/100 cc.	— 99%
		14-16 Gm/100 cc.	
	P.M.	13.5 Gm/100 cc.	— 91%
2nd day		14.4 Gm/100 cc.	— 98%
3rd day		14.6 Gm/100 cc.	— 99%
8th day		12.8 Gm/100 cc.	— 86%

Although on admission it was estimated that Mr. Carter's blood volume was 50 per cent below normal his hemoglobin was high. This can be attributed to the fact that body fluids had not yet had time to pass into the blood stream and dilute the blood to its normal volume of circulation. The giving of 2000 cc. of whole blood intravenously during his first 24 hours in hospital replaced a large number of the red cells lost in the hemorrhage, and helped keep the hemoglobin estimation high. After 8 days in hospital his hemoglobin dropped to 86 per cent. One might assume this was caused by the fact that the transfusions had ceased so no more blood cells were being added, and body fluids had ample chance to dilute the blood to its normal volume. Therefore the blood was thinner than normal and the cell volume per cc. was lower.

Non Protein Nitrogen	*normal*
1st Day 43 mg/100 cc.	23-45 mg/100 cc.
3rd Day 36 mg/100 cc.	

The N.P.N. estimation is lower on the 3rd day because the body cells are utilizing the ingested proteins more completely; therefore there is a smaller volume of waste to be excreted.

Urinalysis

Urinalyses were carried out daily and the results showed an occasional epithelial and white blood cell, but this can be considered normal.

sugar + 2	normal — neg.
acetone strong +	normal — neg.

The + 2 sugar may be explained by the fact that in gastric ulcer patients the glucose tolerance curve is frequently abnormal. There is some disagreement concerning the possible pathogenic significance of this fact.

The presence of acetone in the urine denotes an improper fat metabolism.

Treatments and Medications

Treatment of the peptic ulcer is essentially medical. Surgery, if indicated is usually undertaken for the complications and not for the lesion itself.

Aims: to avoid complications, to create best possible conditions for healing, to prevent recurrence.

Immediately following Mr. Carter's admission to hospital a consultation was held. The following orders were written and carried out:

Complete bed rest
Hemoglobin estimation
Typing and cross matching for blood for immediate transfusion
Blood pressure and pulse q.1 h. and report changes
Record intake and output
First week ulcer regime
Morphine gr. ¼ stat, and gr. 1/6 q.6 h.
Probanthine 50 mg. q.i.d.
Daily urinalysis including microscopic examination
Sodium luminal gr. ii h.s.

Physical and mental rest for Mr. Carter was striven for at all times. An attempt was made to alleviate apprehension and fear because the gastrointestinal tract is so sensitive to emotional stress. By encouraging him to voice his fears, by paying attention to any worries he expressed, and by explanations of all treatments and procedures, we felt that a major step was taken towards our aim of mental rest.

Because of hourly pulse and blood pressure readings for the first few days physical rest was a real problem, but by the wise use of sedation to keep the patient drowsy we gained our objective. On all occasions he was disturbed as little as possible, and he did manage to sleep between intrusions. On his third hospital day Mr. Carter was allowed up in a chair. He tolerated this very well, and his activity was gradually increased.

The relief of pain is of extreme importance in ulcer patients because pain leads to mental distress which in turn leads to more pain. Pain also increases gastric contractions and this can promote the possibility of hemorrhage. Upon his arrival in the ward Mr. Carter received morphine gr. ¼ and at the end of each six hour period following this for eight days he received morphine gr. 1/6. This kept him completely pain-free. After his eighth day the morphine was ordered to be given only when necessary and the pa-

tient was watched carefully for signs of pain. None appeared, and the morphine was unnecessary thereafter.

Probanthine 50 mg. was given to Mr. Carter four times daily to decrease gastric motility and secretions thereby eliminating a source of irritation and pain. By careful observation it was decided that this drug was achieving its effect. After three days the doctor felt that it was no longer necessary. In connection with the use of Probanthine, it is well to remember that constipation and urinary retention are two of its untoward effects. On one occasion it was necessary to catheterize Mr. Carter. One half ounce of milk of magnesia given twice daily helped avoid constipation.

Antacid therapy in the form of amphojel played a major role by protecting the irritated gastric mucosa from acid secretions. It helped to eliminate the cause of increased pain, hemorrhage, and mucosal damage, and to provide a better environment for tissue repair. The dosage started at one ounce hourly day and night, and was gradually decreased to one half ounce four times daily.

The doctor chose phenobarbital as the agent to be used to keep Mr. Carter as relaxed as possible. Sodium phenobarbital gr. ii hypodermically kept him fairly drowsy during his first night in hospital. During the following day phenobarbital gr. ¼ q. 1 h. was given until the patient became soporific. The order was then changed to gr. ½ q.i.d. This kept the patient relaxed, and fairly drowsy at times, but did not allow him to become stuporous.

Diet

Diet is very important in ulcer treatment. It is essential that the patient understand the reasons for his diet so that his cooperation may be gained and he will realize the necessity for dietary restrictions following his discharge.

Dietary aims: Adequate nutrition to
keep something in the stomach at all times to neutralize the acid;
avoid stimulation and irritation of the mucosa;
high caloric value;
easily digested foods.
high protein intake to promote repair;

Sippy milk (9% cream) is ideal for this purpose.

Mr. Carter received his first feedings (sippy milk three ounces, and amphojel one ounce) by gavage. Care was taken that the feeding was warm, and that no air was introduced into the tube. Gravity drainage was used to introduce the feeding into the stomach so that no undue pressure would be exerted against the gastric walls. A small quantity of warm water was introduced after each feeding to clear the tube.

Early in his second hospital day Mr. Carter complained of epigastric distress, was nauseated with 24 ounces of yellow emesis, and expelled his Levine tube. It was decided that the tube was no longer necessary. The patient tolerated his diet very well without its use. The gradual progression to second and third week ulcer diet was tolerated extremely well. It had a definite psychological value in that the patient recognized dietary progression as a sign of an improvement in his condition.

Vitamin supplements in the form of B-plex$_{12}$, ascorbic acid, and halibut liver oil were added to the diet after the first week to help achieve adequate nutrition.

Blood Transfusions

Because of the severity of the hemorrhage Mr. Carter had suffered before his admission, it was necessary to replace 2000 cc. of blood through the use of transfusions. Laboratory examination disclosed his blood type as O negative, but because of an inadequate supply in the blood bank, and the fact that this was a male patient, it was acceptable to use O positive blood that had been carefully crossmatched against his.

It was necessary to watch constantly for signs of an untoward reaction such as flushing of the face, headache, chills, muscle pain, or dyspnea which would show an incompatibility between donor blood and that of the recipient. Early in the administration of his second 1000 cc. of blood Mr. Carter's face became very flushed. The transfusion was slowed and the untoward symptom vanished. This was the only reaction

that arose during the transfusions. If a reaction had been suspected at any time the transfusion would have been clamped, and the proper authorities notified.

On admission Mr. Carter had a blood pressure of 170/100, but about three hours later it had dropped to 80/60 — an extremely low level for a hypertensive patient. Next morning his doctor remarked:

> At the termination of 1000 cc. blood the patient's general condition is only satisfactory — B.P. 138/80. He needs more blood but I think it can be assumed that he has stopped bleeding. Any sign today indicating further hemorrhage would be an absolute indication for operation as an emergency.

After the absorption of the second 1000 cc. of blood Mr. Carter's blood pressure reached 150/92. For the following two weeks it ranged between 125/74 — 150/92. No signs indicating further hemorrhage were noted.

Nursing Care

The nursing care given Mr. Carter always aimed at establishing his confidence in his nurses and doctors, the hospital and its staff in general. Routine nursing measures were used to keep the patient and his linen clean, and his bed comfortable. Special attention to oral hygiene was very important. Doctor's orders were carried out promptly, and the patient's response to treatment was charted accurately.

Mr. Carter was observed at all times for restlessness. This is a significant sign that may mean the presence of hemorrhage, urinary retention, or nervous tension, all of which must be avoided. Any special change in condition must be reported and recorded. The taking of blood pressure and pulse, and the recording of the rate and quality each hour for his first three days in hospital, and twice daily thereafter helped the doctor to gain an accurate estimation of Mr. Carter's circulatory picture.

In respect to diet it was extremely important that feedings were given on time, that the proper amount was given, that the milk was always fresh, and at no time were dirty glasses allowed to collect at the bedside. An accurate record of intake and output was kept, and the patient's tolerance to diet increase was noted. Because hourly feedings and constant repetition of the same food was already a strain on the patient, it was essential that feedings should be delivered with the right attitude, that the patient was not allowed to feel that the feedings were a burden to the nurse, and something to be disposed of as quickly as possible. Recording the amount and type of emesis was a nursing responsibility also.

As the patient's condition improved he was encouraged to gradually decrease the time spent in bed, and to increase his exercise. Care was taken that he did not become tired.

It is easier on the patient, and on his relatives, if they are informed before entering his room of any special treatments that are in progress. A simple explanation is all that is necessary, and it will save the relatives a great deal of mental distress. The patient will also feel better because his friends will not be exchanging worried glances.

Mr. Carter had been informed during his early hospitalization that an operation was essential and a date was decided. It then became a nursing responsibility to give the patient an adequate physical and mental preparation for this procedure to prevent him from going to the operating room in an apprehensive and anxious state. Explanations of procedures that could be expected both pre- and postoperatively were given. The patient was encouraged to exercise his arms and legs, and to practise deep breathing in preparation for this postoperative period. He was crossmatched for six pints of blood in preparation for surgery. Mr. Carter was transferred to a surgical floor to allow for adequate orientation before his operation.

He was very cheerful when he left our ward, but he was sorry to leave his new friends. He had a good attitude towards his coming surgery, and looked forward with anticipation to a rapid postoperative recovery, and the day that he would leave the hospital.

The Operation

Under sodium pentothal and nitrous oxide, and using the drug Flaxedil to

gain the desired muscular relaxation, a two-thirds subtotal gastric resection was performed on Mr. Carter. The surgeons' task was made more difficult because the patient's obesity had caused the transverse colon to become very enlarged, and the mesentery very short. Before the incision was closed a 1-inch Penrose drain was placed near the duodenal stump and brought out at the lateral end of the incision. A Levine tube was passed via the patient's nares to the stomach. During the operation the anesthetist kept a constant check on Mr. Carter's blood pressure, and administered 2000 cc. of blood, and 500 cc. of I.V. solution to help replace the blood loss, to help maintain the blood pressure, and to lessen the chances of shock.

Postoperative Care

On return to the ward a retention catheter was inserted and left in place for the first three postoperative days to avoid the complication of urinary retention. The doctor also ordered chloromycetin to be given daily as a precautionary measure, and Bionet lozenges every two hours to help relieve the throat irritation caused by the Levine tube. The irritation of the throat mucosa by the tube caused an increase in mucous production. This resulted in much discomfort.

Blood chemistry readings were taken frequently, and very extensive intravenous therapy was instituted to maintain the patient's electrolyte balance. The doctors ordered demerol to relieve pain, and Largactil to help the patient rest.

After four days, because of a constant seepage of bile onto the dressings a catheter was inserted into the wound and a Stedman motor attached to the drain. The doctor ordered aqueous penicillin as the agent to ward off infection. All throughout the postoperative period the drain was a constant source of trouble. Bile seepage still appeared around it and caused a large red excoriated area on the patient's skin. Barrière cream and vaseline dressings were ordered for the area but the patient seemed to get little relief. The orders were changed to cod liver oil dressings, zinc oxide, and later to aluminum paste before the desired effect was achieved. Leaving the abdomen exposed and applying the infrared lamp three times daily gave the patient a great deal of comfort. The area gradually became less troublesome. Eleven days postoperatively the skin sutures were removed, and about three weeks later the drain was taken out and the patient was taught to do his own dressings.

The Levine tube was left open immediately postoperatively, and the length of time it was clamped off was gradually increased. At first the clamping caused the patient much discomfort, but this decreased little by little. Mr. Carter was restricted to sips of water for over two weeks until the Levine tube was removed. He graduated to clear fluids, but the tube had to be reinserted next day because of persistent nausea and bile emesis. When the tube was again removed the patient was placed on a postoperative gastric regime of equal parts milk and water which he tolerated very poorly. This diet was changed when it was found that chicken broth was more agreeable to the patient, and better tolerated. Because nausea was still troublesome at times the dietary increase to pureed and bland foods had to be made very slowly. Vitamins A and B, ascorbic acid, and B-plex were given throughout the postoperative period to supplement the intravenous therapy and the diet. A careful record of intake and output was kept at all times.

Mr. Carter was encouraged to move about in bed and dangle his legs early in his recovery period, but he seemed reluctant to do so. Later when the tubes were clamped, he was helped up into a chair each day. Getting him up was a problem for his nurses because of his size and weakened condition. Also, his periods out of bed had to be fitted in between the intravenous fluids that were running almost constantly. As he became stronger, the doctor encouraged him to get up for at least one half hour before and after each meal, and to spend as much time as possible out of bed. Mr. Carter lost a great deal of weight. He was very depressed at times because of his slow recovery, and the complications that had arisen. But as his strength returned he began to look forward to his visits with other ambulatory patients and was very cheer-

ful at the thought of being home for Christmas. The specialist called in to perform the operation stated that the complications encountered during Mr. Carter's recovery period will in no way alter the fact that only 3-5 per cent of ulcer cases of this type are recurrent. Mr. Carter's prognosis then is very good.

Patient Teaching

The morning bath provided an excellent opportunity for patient teaching. During discussions about peptic ulcers in general, and his case in particular the importance of proper diet, rest, exercise, and hygiene was stressed. He is not in the habit of using alcohol and tobacco, and was cautioned against their use in the future. The avoidance of stress situations will play a major role in the prevention of ulcer recurrence. A regular medical examination, and prompt reporting of any of his previous symptoms if they return were advised. Mr. Carter was cautioned against self-medication and the use of patent medicines. Only medications ordered by the doctor should be used, and care should be taken that the doctor's orders are followed carefully.

Pyloric Stenosis

Adeline Pavan

Well, it didn't take me too long to make a second trip to hospital! I am just one month old and hardly yet accustomed to my pretty blue bassinet! It seems ever since I can remember, although I enjoyed my bottle very much and could hardly wait for it, I just could not seem to retain my feedings. Our doctor advised Mother to take me to the hospital. She seemed quite surprised when the nurse placed me on the scales (without a stitch of clothes on!) and informed her that I weighed 7 lb. 8 oz. — quite a difference from my birth weight of 8 lb. 6 oz. Mother explained that since she never did get around to buying a pair of scales she hadn't realized that I had lost so much in such a short time (and with me crying such a great deal!) These new mothers! — it's not always an advantage to be a "first."

I was all set, I thought. My doctor had left orders that my lactic acid formula (boiled, acidified milk, curdled for easier digestibility) was to be thickened with rice pablum. I was to be propped up with pillows in a high Fowler's position to see if that would help me to keep my formula down. But it didn't. Well, anyway it was the latest in comfort. Later on in the evening, when I was certain that everyone had forgotten that my feeding was due, along came a nurse and strapped a test tube to me. This would be easier on the diapers I supposed, as well as on the nurses!

Next morning the fun really began. A new nurse came in and tried to make friends in a real hurry. No wonder, all she wanted was to make my toe bleed! Then I had no sooner closed my eyes when I had company again. He turned out to be a doctor who had been sent by our family doctor to see me. I was promptly transported to the treatment room where Dr. Barry poked me again and again in my tummy. His first remark was that I "looked" like a "pyloric" (and having lost some more weight didn't help the situation any!).

Then there was some talk about waves! He turned to the student nurse and asked if she knew what my symptoms should be. She replied emaciation, loss of weight, projectile vomiting and peristaltic waves. "Exactly what kind of waves," he queried, "everyone has visible, peristaltic waves." She seemed bewildered. I tried to tell her that they were reverse peristaltic waves

This nursing care study was written by Miss Pavan during her pediatric affiliation as a senior student at St. Joseph's Hospital, Guelph.

since that was the only kind I had ever known. I realize now that this was abnormal. Then the doctor proceeded to feed me and poke my tummy at intervals. Yes, those special waves were certainly there along with some kind of firm, hard mass about the size of an almond which, on palpation, was felt going from left to right. Dr. Barry was quite convinced that it was pyloric stenosis. Just as if to verify his thoughts, up I spit (although I didn't want to) clear over the side of the table!

At that same time Dr. Kay entered and they started talking about such things as surgery, dehydration and loss of skin elasticity (the results of becoming all dried up!) My laboratory reports which I didn't understand at all went something like this:

> Hematology: Hemoglobin 108%, WB C 13,600. Urinalysis: Alkaline reaction, occasional epithelial cells, 1-2 pus cells, ammonium phosphate crystals present.

They finally concluded that I should go down to the x-ray department for a barium swallow to confirm the diagnosis.

Whatever that was going to be I felt it would be bad enough and was already working myself into a sweat when to my horror I heard Dr. Barry tell the nurse to prepare for a cut-down! That was it, I was sure! My leg was strapped securely to some immovable object to keep me from moving so the cannula would stay in the vein and all I could remember after that was a sharp prick. In a matter of minutes it was all over. Dr. Barry gave explicit orders that the solution of 5% glucose in water and 5% glucose in saline was to run at 25 cc. per hour or the equivalent of 6 gtts. per minute. He went on to explain that too much fluid could be just as dangerous as a deficiency in that I could develop a fatal pulmonary edema. The nurse was also cautioned to observe carefully for signs of muscular twitching due to tetany which results with a loss of chlorides from the body in which case calcium must be immediately administered.

From the way everyone was buzzing around I just knew there was something else brewing. The next thing I knew I was eagerly sucking a new formula that someone from x-ray had been so kind as to make up for me. Oh, such a tasteless, chalky mixture to feed to a starving infant! It was only a matter of seconds until up it all came to the dismay of everyone around me. The next step entailed a quick change from the treatment room, down the elevator onto another floor into another dark room only to be fed that awful formula again. The doctor here stated that there was a marked dilation of my stomach with apparent obstruction at the pyloric end. Surely all this inhuman treatment was bound to end soon.

I had had a most trying day and could hardly wait to get to sleep. They must have read my mind because the next thing I knew I was transferred to another bed with a glass top and sideview. My, it was nice and warm in there! Mommy and Daddy had made fancy plans for my baptism that was to have taken place the following Sunday but since I was scheduled for the operating room the next day, I was baptized in the hospital.

The next morning they started to work on me bright and early. This time when the lady with the tube tray jabbed my toe, I overheard something about being typed for cross-matching. Following this a very petite nurse came along and slipped a long narrow tube into one of my nostrils. I simply swallowed it in order to get it out of the way! Before I had time to worry or fret, I was whisked away to the operating room and put fast asleep. Peace at last!

I don't remember too much about what happened during the rest of the afternoon, I was so drowsy. In one instance, I remember that same little nurse suctioning my throat and how much better it felt after it had been cleared of all that mucus and the tube had been removed. Then I listened while my doctor told her about what he had done to me.

> Pyloric stenosis is a narrowing or tight constriction of the lumen through the pyloric orifice of the stomach which produces an obstruction, more often partial than complete. Two factors cause constriction. One is hypertrophy of the circular muscle about the pylorus, and the other is spasm of this muscle. Projectile vomiting is the chief symptom.

Jimmy is a typical case being a one-

month old, male infant. Pyloric stenosis occurs about three times more frequently in male than female infants and appears to involve first-born children primarily. It does not usually appear before two to three weeks after birth or after two months of age.

The operation that we performed today is the one of choice for this condition and is known as the Fredet-Rammstedt operation. It consists of an incision through the hypertrophied circular muscle down to, but not through the mucosa, and parallel to the pyloric lumen, thus allowing the pylorus to expand.

All this meant very little to me but I became most attentive when I heard the word "formula" mentioned. A schedule to start four hours postoperatively, had been made out for me in which I would be given alternate feedings of two drams of glucose then two drams of formula (full-strength lactic acid milk). This was to be increased by two drams every feeding every four hours thereafter until two ounces were reached. Should I vomit, the next feeding would revert to the amount I had last retained and work up again. I was to be fed slowly with a small-holed nipple and feedings were to be interrupted frequently for bubbling. At the end of the feeding I was to be placed on my right side to lessen the emptying time of the stomach, and also to prevent any aspiration of vomitus. My but they were fussy! My feedings did stay with me and I could tell everyone was so pleased I was so thankful that at last my doctor had straightened everything up. I longed to tell him so, but I was a little too young then.

Oh, I had my difficulties with bouts of emesis after some feedings, but I had a lot of mucus in my throat that I just had to get out. Just retaining part of my formula was a whole new experience for me and that is probably why even the addition of Nestargel to thicken my formula didn't really help too much. Actually all I needed was a little bit of time to get adjusted.

A small dressing covered the incision on my tummy. The nurses would peek at it now and then for any sign of bleeding. I was given antibiotics to prevent any infection from developing. I managed to progress quite favorably, and with the appearance of one soft yellow stool, the nurses seemed very pleased and said something about resumption of peristalsis. They must have sensed my hunger because on the third postoperative day sugar preparation was added to my formula and the amount was increased to one and one half ounces every two hours and gradually to three ounces every three hours the following day. Now I was really living!

Before I realized it, it was time to go home. Although I was ever so grateful to everyone for taking care of me so faithfully, (I now weighed a pound more than my birth weight!), I was very happy to see Mommy. The nurse told her to be sure to burp me often when feeding me, to keep a clean dressing on my incision and to be sure to see doctor for a checkup before too long.

Nursing Sisters' Association

Appointed to the National Executive of the Association were: *E. Purdy*, Dartmouth, N.S., pres.; *E. Pepper*, Ottawa, past pres.; *M. Haliburton*, Halifax, vice-pres.; *D. B. Lodge*, Ottawa, vice-pres.; *H. Corbett*, Victoria Gen. Hosp., Halifax, sec.-treas.; *A. Egan*, 85 Walnut St., Halifax, corr. sec.; *M. J. Russell*, Halifax, social convener; Mmes. *M. C. Macdonnell*, Halifax, *L. Vatcher*, Dartmouth, councillors. Honorary presidents are: Mrs. *S. Ramsay*, Montreal and Misses *E. L. Smellie*, *A. Macleod*, Ottawa.

The following members were elected to office at the annual meeting of the Halifax Unit, held in conjunction with the Armistice Day dinner: Mrs. *L. Vatcher*, pres.; Mrs. *M. C. Macdonnell*, vice-pres.; *Mary Romans*, treas.; *Mary Fraser*, sec.; Mrs. *Vera Fiendal*, convener, sick visiting; Mrs. *S. A. Bushell*, convener, entertainment.

Nursing Care in Hemorrhoidectomy

PATRICIA ROWLAND

HEMORRHOIDS

HEMORRHOIDS OR "PILES" consist of varicosities in the hemorrhoidal veins in the rectum. There are two types — internal and external hemorrhoids. Internal hemorrhoids are those occurring in the superior and middle hemorrhoidal veins. They are found within the rectum or prolapsed through the anal sphincter and are covered only by rectal mucosa. External hemorrhoids are those originating from the inferior hemorrhoidal vein and occur outside the anal sphincter being covered by anal skin.

The etiology in almost every case has proved to be a congenital or hereditary weakness of the venous structure that has been aggravated by one of the following conditions:

1. A direct or local pressure on the veins of the rectum caused by:
   a. poor bowel hygiene, for example chronic constipation
   b. pelvic or abdominal tumors either benign or malignant
   c. a pregnant or misplaced uterus
2. A central obstruction of venous return due to:
   a. decompensated heart failure
   b. cirrhosis of the liver.

The weakness may be present but hemorrhoids are not usually found in children. However, it is a very common ailment among adults of all ages with the most frequent causes being pressure upon the veins from pregnancy and/or poor bowel hygiene.

The blood supply to the rectum is returned via the inferior, middle and superior hemorrhoidal veins that empty into the common iliac veins. Like other veins, the hemorrhoidal veins consist of three layers — intima, media and adventia. Veins are thinner-walled than arteries and less elastic due to the poorly developed medial layer. The veins have many tiny semilunar valves which form the advential layer. These numerous valves do not obstruct the return flow of blood to the heart, but they do prevent a backflow.

When the blood flow is obstructed due to local or central pressure, the volume of blood in the veins builds up. The task of trying to force blood uphill is difficult enough without added burden. The inability of the veins to cope with the obstruction results in a breakdown of the valves. The veins become dilated, tortuous, and elongated. Hypertrophy of the medial layer takes places followed by atrophy and replacement fibrosis. The intima and adventia layers also become fibrosed and thickened. As thickening is irregular, pouching occurs in the vein wall. Thrombosis in these pouches is common. Internal hemorrhoids frequently prolapse through the anal sphincter causing considerable discomfort; if the blood within them clots and becomes infected they are said to be thrombosed.

When thrombosis takes place or internal hemorrhoids prolapse there is considerable pain. This is often called an "attack of hemorrhoids." Ordinarily, there is pain in the passage of stool and there may be itching and burning sensations between and especially after defecation. Internal hemorrhoids often bleed at defecation. The amount of bleeding may range from a few drops to several ounces. If bleeding is allowed to persist over a long period, secondary anemia may result.

THE PATIENT

One spring evening a tall thin gentleman Mr. Stone, was admitted for elective surgery of internal and external prolapsed and thrombosed hemorrhoids.

Since his birth, 48 years before, he had lived and worked in a lumbering district. Family financial difficulties made it necessary for him to leave school when a boy of twelve. A boy doing a man's work does not produce the healthiest specimen of mankind, and this certainly proved the case for young "Jim" Stone. A very poor diet, meals at irregular times, little or no health teaching in the large family at home, resulted in generally poor health and a

Miss Rowland will graduate this year from General Hospital, Belleville, Ont.

rather scrawnily built man. However, Jim developed his skill as a lumberjack and at the age of twenty decided to go into the business for himself. Long hours of backbreaking labor proved worthwhile to him as he was able to support a wife and a family of three boys and two girls. He never mentioned any clubs to which he might have belonged but spoke briefly of family get-togethers around the fireplace and of the occasional visit to the little church near his home.

Mr. Stone was introduced to his fellow patients and the evening nurse explained to him the hospital routine so that he would have some idea what to expect and thus would be more at ease.

Medical History

His admission temperature, pulse, and respirations were normal but his blood pressure was only 90/56. He was very pale and thin.

His family history disclosed a marked tendency towards anemia. His father had had hemorrhoids but had never received medical attention. Upon questioning he told us that his mother had been bothered by the veins in her legs and by sores on her ankles. These were most likely varicose veins and ulcers which stem from the same venous weakness as do hemorrhoids. Mr. Stone's living circumstances had been partially responsible for his slide into poor health habits. In childhood he had had the usual diseases but had always seemed to be ill with them longer than normal. For the past 15 years he had been experiencing severe pain and bleeding on defecation. Thus over the years he had often disregarded the urge to defecate to prevent the discomfort he knew would ensue. Chronic constipation and increased pain and bleeding during defecation proved to be the result of his efforts to overcome the condition.

Mr. Stone had not been to a doctor about his condition until now when he found that he could no longer endure the constant itching, burning, and severe pain. He realized, too, that lately he tired more easily, that his work seemed increasingly strenuous.

Diagnostic Procedures

When the doctor visited, he did a rectal examination to determine the location and extent of the hemorrhoids. Although it was very evident that hemorrhoids were present, bright blood in the stool is an important clinical sign. The doctor realized the great importance of searching the alimentary canal thoroughly for other causes of the bleeding such as cancer of the rectum, bleeding ulcer, or hiatus hernia. He ordered a barium enema and x-ray of the lower colon on the following day. For this test it is very important that the lower bowel be completely emptied. Otherwise particles of fecal material might lead to a wrong diagnosis. This cleansing was done by giving Mr. Stone enemas until the return soap suds solution was clear.

A gastrointestinal series of x-rays were also ordered for the following morning. The nurse explained to Mr. Stone that he was not to eat or drink after midnight and that he could have no breakfast the following morning, in order that the x-rays might be accurate. To make sure no one tempted him with food she hung a "no breakfast" sign on his bed.

Following the x-rays, low residue diet was ordered for Mr. Stone in order that the fecal content or bulk would be small and the hemorrhoids less irritated.

Tuinal grains 3 was ordered as a sedative so that Mr. Stone might obtain a good rest prior to surgery. Aspirin phenacetin compound with codeine grains ¼ was ordered for pain. Wyanoid rectal suppositories were also ordered three times daily for the same reason. Wyanoid is an analgesic compound prepared in cocoa butter. The cocoa butter melts at body temperature releasing the analgesic compound.

Several laboratory tests were ordered for Mr. Stone. They were urinalysis, white blood count, hematocrit, prothrombin time and standard test for syphilis. (*See next page*)

The x-rays proved to be negative for any abnormalities. Since the patient must drink a barium solution for the gastrointestinal series, a laxative was ordered that night and the following morning to clean out the bowel as barium can be very constipating.

During his second day, Mr. Stone developed a cold. He began to expectorate thick, yellowish blood-streak-

TEST	RESULT	NORMAL
1. *Urinalysis*		
color	clear, bright yellow	clear, straw-colored or amber
specific gravity	1.019	1.005-1.025
albumin	negative	negative
sugar, microscopic examination of sediment for casts, red blood cells, and pus cells	negative	negative

Significance:

a) Abnormalities of color may denote such things as hemorrhage of the urinary system; or disorder of the liver or gall bladder since bile is noted in the urine at an early stage.

b) Sugar in the urine might denote that the person was a diabetic.

c) Pus cells would denote the presence of infection in the body or kidneys.

2. White Blood Cell Count	12,900 per cubic millimeter of blood.	5,000-9,000 per cubic millimeter.

Significance:

The white blood cell count increases under certain circumstances, for example infection and leukemia. The increase in Mr. Stone's white blood count was due to infection that might be present in the thrombosed hemorrhoids or from some other source in the body.

3. Hematocrit	37%	45%

Significance:

The hematocrit measures the number of packed red blood cells per cubic millimeter of blood. Mr. Stone has had rectal bleeding for some years which accounts for the hematocrit being slightly low.

4. Serum Test for Syphilis	negative	negative.

Significance:

This is a standard blood test done on all patients entering the hospital to discover and prevent the spread of venereal disease.

5. Prothrombin Time	20 seconds.	15-30 seconds.

Significance:

This test showed that Mr. Stone's prothrombin time was normal. Prothrombin is important in the clotting process; if the time is longer than normal vitamin K would be given to lessen the bleeding time since vitamin K influences the production of prothrombin in the liver.

ed phlegm and was coughing considerably. The nurse telephoned the doctor who postponed the operation until the cold had cleared up. Mr. Stone was very sensitive and embarrassed about his condition, and was anxious to have the operation done. The nurse had to explain to him that although the operation was a minor one, a heavy cold such as his could easily develop into postoperative hypostatic pneumonia. Mr. Stone's anemic condition also rendered him more prone to infection. He was not considered a good operative risk.

Penicillin with streptomycin grams ½ was ordered to overcome his cold. It was to be given twice daily by intramuscular preparation.

Syrup of codeine was ordered for his cough. Tablets of aspirin phenacetin compound with codeine were ordered to relieve the headache accompanying his cold and to keep his temperature down.

Two days later Mr. Stone was much better. He was given a chest x-ray to make sure that his lungs were clear and to see if definite operative plans could be made. He was also given an

intramuscular injection of vitamin K to lessen the danger of hemorrhage. Vitamin K stimulates the synthesis of prothrombin by the liver. This is important in the clotting process of the blood.

Clotting Process: When injury occurs: thromboplastinogen forms thromboplastin
thromboplastin + calcium + prothrombin forms thrombin
thrombin + fibrinogen forms fibrin
fibrin + cells of blood forms clot.

Preoperative Care

The operative area was shaved thoroughly by the orderly. It is necessary to remove all the hair since bacteria are harbored in it. The colon must be clean so that there will be no bowel movements for a few days to give the operative site a chance to heal. A bowel movement too soon after operation would cause pain, trauma and hemorrhage.

Mr. Stone was given his usual dose of Tuinal grains 3 in order to get a good night's rest. At 7:00 the following morning, morphine grains 1/6 and hyoscine grains 1/150 were given hypodermically. Morphine is given preoperatively to enhance the action of anesthesia as it depresses the central nervous system. Hyoscine is given to dry secretions of the mouth, throat and nose thus preventing their aspiration. Mr. Stone had not been allowed to have anything by mouth since midnight; thus any previous food would have left the stomach by the time of operation. At 8:00 A.M. he was taken to the operating room.

The Operation

Sodium pentothal five percent was given intravenously as an induction anesthesia. It is rapid in action and is used mostly for induction or for very short operative procedures. The recovery from pentothal is quick but occasionally it causes a mental depression that lasts for several hours.

Mr. Stone was further anesthetized with nitrous oxide and oxygen given by mask. Nitrous oxide is one of the oldest inhalation anesthetics known. It is given with oxygen because when given alone it may produce asphyxia.

For the operation Mr. Stone was placed in lithotomy position. Before being draped with sterile drapes the area about the rectum was cleansed well with sterile water, Phisohex, and merthiolate tincture. The operation consisted of ligation of the base of the hemorrhoid and then amputation. In this manner internal and external hemorrhoids were removed from three different areas about the rectum. A vaseline pack and a catheter were inserted into the rectum to keep the anal sphincter dilated and allow for drainage of any internal bleeding. This also makes it easier to recognize hemorrhage as otherwise it may be insidious.

Proctocaine was injected intramuscularly at several points proximal to the anus. Proctocaine is similar to novocaine in that it is a local anesthetic but it is prepared in an oil base so that it is long-acting. It is effectual for 24 to 48 hours. The dressings were held in place by a firm T-binder.

Nursing Care

Mr. Stone was taken to the recovery room where he could be closely watched until he had recovered from the anesthetic. His pulse and blood pressure were checked frequently to denote the presence of shock or hemorrhage. A rise in pulse or a drop in blood pressure are signs of hemorrhage. His dressings were also checked frequently for excessive bleeding. His pulse remained stable at 80 and his blood pressure at 110/64.

Upon his return to his room the vitamin K was repeated to insure against hemorrhage. It was the nurse's responsibility to check for bleeding and to check the pulse and blood pressure every hour for eight hours.

During the next few days, Mr. Stone experienced a great deal of severe rectal pain. He was given morphine grains ⅙ every three hours as necessary. It has powerful analgesic properties and so it is very useful for relief of pain. However, with certain individuals, very little relief is obtained from it. The nurse noticed that the morphine was not giving Mr. Stone much relief. She notified the doctor who changed the order to Demerol 100 mgm. to be given intramuscularly every four hours as necessary. Demerol is a synthetic drug

that often gives relief to those who do not get it from morphine. It is not as constipating as morphine though it is habit-forming.

The penicillin and streptomycin injections twice daily were continued as a prophylactic measure against infection.

The nurse encouraged Mr. Stone to breathe deeply and to cough occasionally in order to expand his lungs and prevent any upper respiratory infection. She also encouraged him to move about in bed especially exercising his legs to prevent formation of a thrombus. Mr. Stone obeyed these instructions very well needing only an occasional subtle reminder from the nurse. He was started on a fluid diet that was gradually increased to soft on the second day and to a full diet on the third postoperative day.

Preoperatively the nurse had noticed that Mr. Stone rather neglected good health habits. Health teaching had to be done in such a way that Mr. Stone would be learning without realizing it and his pride in himself would not be hurt. As she was bathing him, they discussed general good health and hygiene. The nurse stressed the importance of well balanced, nutritious meals and the importance that diet plays in the regular emptying of the bowel. She told him that good bowel hygiene was important to prevent recurrence of the hemorrhoids. At meal times she pointed out what she had meant by a well balanced diet.

During a visit from his wife Mr. Stone introduced her to the nurse who remained for a moment to become acquainted with her. Before she left Mrs. Stone asked the nurse if there was anything she could do to help. The nurse explained what she had told Mr. Stone. She suggested to Mrs. Stone that she could encourage good health habits and also prepare nourishing rather than just filling meals. Sufficient rest was also important to her husband's general health. This he obtained in the hospital but would he at home? Mr. Stone was not getting any younger. In the next few years he would have to cut down on the amount of labor he could do. He no longer had children to support and he had younger men working for him who could gradually assume the more strenuous tasks. All these little suggestions the nurse also discussed with Mr. Stone, hoping that he would consider them when he returned home.

During his stay in hospital the several visits of Mr. Stone's minister seemed to encourage him although he would never have admitted it. He did not have many visitors and often became very moody around visiting hours. He appeared to feel out of tune with the busy hospital routine compared to his freedom in the bush. Only once did he take his feelings out in rage. It seemed to give him a sense of satisfaction that just once he had "ruffled the quiet feathers" of the busy hospital schedule.

Mr. Stone's progress was very good in the days that followed surgery. He was turned from side to side for comfort or given a rubber air ring to take the pressure off the rectal area when lying on his back. On the second postoperative day the rubber drain and vaseline pack were removed. A digital examination was done. Diothane ointment was then inserted into the rectum and whenever necessary for discomfort thereafter. Diothane is an analgesic anesthetic ointment used to relieve rectal pain by dulling the sensory pain receptors in the area. Mineral oil was ordered every morning and evening to soften the fecal material so that a bowel movement would not traumatize the incisions. Thirty cubic centimeters of mineral oil was ordered to be instilled into the rectum prior to evacuation to facilitate the passage of stool.

Mr. Stone was very anxious to be up and about. The doctor explained how the veins of the rectum would dilate and that undue pressure on them from the upright position at this point might cause hemorrhage. This simple explanation satisfied Mr. Stone who settled back on his pillows without a word.

On the third postoperative day he was given bathroom privileges and began Sitz baths twice daily. Sitz baths consist of soaking the body in moderately hot water, covering the hips. These baths provide much relaxation and comfort to the sore area of the rectum. The heat increases the blood supply, speeding up the healing process.

Mr. Stone had no difficulty voiding

postoperatively. This is frequently a complication after a hemorrhoidectomy. He would have been catheterized had he been unable to void after all other nursing measures had been tried.

He had a bowel movement on the fourth postoperative day with pain but no bleeding. From then on he had bowel movements daily with little trouble. He continued to take Sitz baths twice daily. By the time Mr. Stone could go home he was eating a full diet, and had established good bowel habits, to both of which he promised to adhere.

Surprisingly enough he had adapted himself to his surroundings. Instead of the rather moody person he had been upon arrival he was quite jovial, getting much enjoyment out of expounding in great detail his many harrowing experiences in the bush. He was discharge a healthier and happier man than he had been for sometime.

Mission to Japan

HAZEL F. NAUDETT

TO VISIT JAPAN at any time would be wonderful. To do so under the sponsorship of two great organizations such as UNESCO and the Canadian Nurses' Association was an unforgettable experience. The East-West Cultural Mission was organized by the United Nations Association Committee for UNESCO under the chairmanship of Mrs. Helen Tucker. The aim was to further UNESCO's long range program of promoting mutual appreciation of East-West culture.

UNESCO has long maintained that since wars begin in the minds of men, it is there that the defences of peace must be constructed. Certainly, understanding is the foundation stone for such defences and how better can we learn to understand one another than by getting to know each other as individuals.

Our mission of 30 members was made up of representatives of educational, cultural and industrial fields from British Columbia to Quebec. The fact that we represented such a variety of interests and were a cross section of Canadians — ordinary citizens — was of interest to the Japanese people who interpreted this as real democracy. From the moment that our plane landed on the runway at the Haneida Airport, Tokyo until we wistfully said "Sayonara" four weeks later we were surrounded by kindness, courtesy and hospitality beyond anything that we could possibly have anticipated. The careful planning of the Japanese National Commission for UNESCO assured us a program of significant and enjoyable activities.

National organizations in Japan cooperated with the National Commission for UNESCO in arranging lectures, receptions, visits to industries and sight-seeing so that we could make the very most use of our time. The day of our arrival the chairman of the Japanese UNESCO Commission, Mr. Tamon Maeda, gave a reception at the beautiful Prince Hotel in Tokyo. This gave the Canadians the opportunity to meet members of the ministries concerned with cultural affairs, education, and international relations as well as members of the National Commissions for UNESCO, UNICEF, the United Nations Associations, International House, and the Japan-Canada Society.

On our second day, Mr. Iyemasa Tokugawa, former ambassador to Canada and presently president of the Canada-Japan Society, entertained at dinner where men and women outstanding in industry were presented. Trade with Canada is a major concern since Japan buys twice as much from

Miss Naudett who is superintendent of Listowel Memorial Hospital, Listowel, Ont. and president of District 2, R.N.A.O. represented the Canadian Nurses' Association on the East-West Cultural Mission to Japan.

Canada as she sells. Canada on the other hand, would like to sell more hard wheat to Japan.

Our group was honored by an official welcome at the semiannual meeting of the Japanese National Commission for UNESCO. In her reply on behalf of the mission, Mrs. Tucker said, "It is the work of UNESCO in your country and mine, to bring the right meaning to the words we exchange. This is education in its true sense — understanding of the heart, as well as of the words spoken by the mind."

One of the outstanding lecturers

Japanese dancing

presented to the Canadians was Dr. Yukio Yashiro, world renowned art critic, who addressed the group on "The Japanese Scroll" at the Society for International Cultural Relations. Among the social highlights was the magnificent outdoor reception given by the Ministry of Foreign Affairs with Mr. Akira Miyazaki, Director of the U.N. Bureau, as host. This was held at "Happoen" formerly owned by the Imperial Family. The reception at the Canadian Embassy, given by Ambassador and Mrs. William Frederick Bull, featured the famous koto performer, Mr. S. Yuize. The koto is an ancient harplike instrument, placed horizontally and played from a standing position.

Travel and sight-seeing were made easy and interesting by the topnotch guides of the Japan Travel Bureau. The absolutely punctual train service required baggage transfers in two minutes flat. The significance of shrines, temples and national treasures was explained in apt and oftentimes humorous English by a former history professor who was our guide throughout the tour.

Before going on the tour that took the group to Hiroshima University and the International Peace Library, our mission was entertained at a unique luncheon by the International Women's Association. The setting was the mansion of the Iwata Iron and Steel Co. and the hostess, Mrs. Emiko Ojima, wife of the president. The Tea Ceremony was demonstrated in the teahouse set apart in the garden especially for that purpose. Flower arrangements and Japanese dancing were taught in the conservatory. The luncheon itself was a culinary masterpiece of Japanese soup, tempura (prawns fried in deep fat), vegetables and exotic delicacies. We were greatly impressed by the skill, charm and ambition of the Japanese women in presenting the culture of the Japanese family to the foreigner.

On our tour, a holiday was arranged in a beautiful new Japanese-style hotel in the mountains above Hakone. Although the aftermath of a typhoon prevented sports and viewing from the cable car, we relaxed in mineral baths, Japanese style. The hot deep bath, up to the chin, is a

A Lesson in flower arrangement

positive treatment for weary muscles, jagged nerves and aching joints. That daily bath keeps the Japanese free from rheumatic pains.

Several days were spent among the historic treasures of Kyoto and Nara, the former capitals of Japan. Kyoto because of its national treasures, was not bombed during the war and now, by vote of its citizens, is considered "The Peace City." Unusual effort is made to make international friends.

Our party was divided into groups of five and, equipped with interpreters, visited private homes. These personal home visits were most instructive and enjoyable. This service is looked after by a special department of the city government. Then we travelled through miles and miles of luxuriant farm land, meticulously manicured into gardens of tea, rice and bamboo, peopled from dawn to dark by hatted, stooping figures.

In Hiroshima we were greeted at the railway station by flowers from the Mayor and a guard of honor of local Boy Scouts. We went directly to the University where President Tatsuo Morito and officials had arranged the ceremony for the presentation of books and UNESCO gift coupons to the International Peace Library. Mrs. Tucker delivered the main address to which President Morito and representative students replied.

After inspecting the University buildings — many makeshift or in process of construction, we visited the Hiroshima Memorial and silently and solemnly placed the gift of flowers. The program did not include a visit to the museum. It was explained, "What we would see there is disastrously awful, it is not pleasant." The following day we went on an early tour of Miyajima Itsukushima Shrine and its Tori Gate in the sea. Lunch later and speeches by the Deputy-Governor of the Prefecture, the Mayor of the city and Dr. Morito who assured the Canadians of the very real appreciation that the Japanese people felt for the compliment paid them by such a visit from Canada. Here, determination that peace shall be maintained, vibrates the very air. We stopped at Osaka, Japan's second city, upon our return to Tokyo. A night at the Osaka Grand Hotel, brand new and as smart as any in this country, gave us an opportunity to evaluate our experiences and plan the last week of free time.

As a nurse I was interested in the welfare of the Japanese people. In Japan, in the early postwar years, there was a tremendous increase in the number of persons seeking social aid and medical services. National concern for improvement in the social security system is steadily mounting. All political parties have shown a positive interest in expanding its benefits. Japan has many laws pertaining to social security: The Livelihood Security Law (for needy persons); Law for the Welfare of Disabled Persons; Child Welfare Law (for children in need of health protection); Health Insurance Law (for employees); National Health Insurance Law (for everyone); Unemployment Insurance Law and Welfare Pension Insurance Law (for employees). The number of beneficiaries under the public aid program totals two million persons.

Extensive preventive efforts are being made to combat tuberculosis, one of the most serious diseases in Japan today. Under the Tuberculosis Control Law, all students, employees in offices and factories and persons under 30 years of age living in designated areas, are required to undergo tuberculin reaction tests and x-ray examination. However, tuberculosis is very much on the decline in Japan as it is in Canada.

Japan has a total of 5,418 hospitals for her 90 million people. There are 31,390 nurses for government health centres and a total of 224,486 nurses and 86,554 midwives. People with whom I had contact, assured me that they had a sufficient number of hospital beds. These hospitals are attended by efficient staffs, many of whom have received postgraduate courses on the North American continent. Hospitals have no shortage of registered nurses and qualifications are much the same as ours in Canada. The minimum education required to enter a training school for nurses is the equivalent of our Junior matriculation.

Salaries for general duty nurses are about $50.00 a month in Canadian money. Salaries or wages of all Japanese people are much lower than in Canada for a comparative position or job. The salaries of nurses are in accordance with the Japanese scale of income. A factory worker would get $20 a month and one in an executive position would get $100. It is interesting to note that most hospitals have a policy that all their nursing staff must live in the hospital residence.

Through the courtesy and influence of Mr. Shu Tomii, former minister of

Foreign Affairs to Canada, a complete tour of Tokyo Kosei Nenkin Byoin (The Tokyo Welfare Pension Hospital) was arranged. This is a 500-bed general hospital, modern in architecture and design and having modern equipment similar to what we have in Canada. It has five stories. The first two floors are mainly for the outpatient department and the remaining three floors are for inpatients. The hospital is open for all types of patients, not only health-insured but private patients as well.

One could write a great deal about a trip like this but space does not permit. The 93 hours of flying time took me across Canada to Cold Bay, Alaska; Tokyo, Japan; Hong Kong; Honolulu, Hawaiian Islands, back to Vancouver and finally Toronto. When one has been privileged to be daily with men and women of another race, to come to know them as friends, barriers of race and color disappear. One's attitude toward them can never be the same again. There wasn't one of us who did not feel a responsibility to make the Japanese better known and better appreciated in Canada. As for the UNESCO major project, "Mutual Appreciation of Eastern and Western Cultural Values," the Canadian mission says with one voice, "You cannot do better than to start with Japan."

In the Good Old Days

(*The Canadian Nurse* — FEBRUARY, 1919)

From an editorial quoted from the *American Journal of Medicine*: The war and the epidemic of influenza with the consequent scarcity of nurses, have drawn attention to the trained nurse and to the fact that she does not supply the suitable agent for ministering to the large body of the ill. The very poor may get free nursing . . . the rich can, and will, pay whatever may be demanded; but the large mass of people of moderate means . . . must be deprived of her services or secure them at what is often a ruinous sacrifice. More than this, a nurse of the highly trained type is not necessary, or even desirable, in the vast majority of cases of illness.

The editor answered: This condition where the people of moderate means find the fee asked by the nurse a burden does undoubtedly exist; but do not these same people complain loudly and long at the charges of the doctors? The family doctor no longer exists; but an army of specialists, each with his ample fee, awaits the sick person. One does not hear the medical profession crying out that there shall be two standards of medical education — one to take the higher work, and the second grade to take charge of the chronic and similar cases where, indeed, it is difficult to get the first-class physician to take much interest.

Hospital trustees are realizing that the class room and laboratory are fundamental parts of the equipment, and that an overworked superintendent of nurses, whose chief duty is administration, cannot be expected to prepare lessons and conduct classes as a side issue . . . Some of us are wondering if the visiting instructor may not find her place here . . . There is a long list of hospitals needing full-time instructors, and not enough women to send to them.

* * *

In one hospital an instructor was asked to give a course in chemistry. No space could be found except the board room where eventually the lectures were given while experiments where conducted in the small lavatory opening off the main room. One young miss handed in her experiments marked "Lavatory Notes!"

* * *

Natural sleep is ushered in by slow, shallow breathing. It is therefore recommended that the person trying to go to sleep should breathe slowly and not too deeply. Sleep usually follows.

* * *

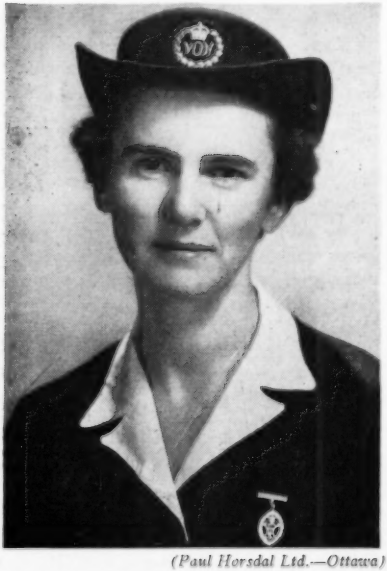
Thirty necklaces have been made from the pearls given by the women of the Empire for the benefit of the Red Cross. Many of the pearls have historic associations.

Nursing Profiles

Ethel Crawford Shaw was appointed regional director for Nova Scotia and Newfoundland with the Victorian Order of Nurses in the latter months of 1958. A graduate of the Hospital for Sick Children, Toronto in 1943, she is a native of Wetaskiwin, Alberta and received her early education in that province.

Miss Shaw was a nursing sister in the Royal Canadian Army Medical Corps for a period of one year before going on to the University of Alberta to obtain her diploma in public health nursing. In 1947 she completed the requirements for her B. Sc. N. and more recently, 1957, she obtained her Master of Science degree from Simmons' College, Boston. Her professional duties have been associated almost exclusively with public health work. For six years she was a staff nurse with the City of Calgary Health Department attached to the school health service. Experience in a Child Hygiene Clinic was followed by her appointment to the Montreal Branch of the V.O.N. in 1957. She remained here until she received her present appointment.

She has always taken an active and interested part in professional activities, as secretary-treasurer of the Alberta Public Health Association for two years, president of the Calgary chapter of the A.A.R.N. for a similar length of time and, most recently, as an executive member of the Nova Scotia Section of the Canadian Public Health Association. Off duty she is an enthusiastic sportswoman with hiking, skiing, swimming and badminton as favorite activities. Playing bridge, reading and photography are reserved for more leisurely moments.



(Paul Horsdal Ltd.—Ottawa)

ETHEL CRAWFORD SHAW

Dorothy Maud Hibbert has been appointed assistant professor in charge of the program in administration of nursing services sponsored by the W. K. Kellogg Foundation at the University of Saskatchewan, Saskatoon.

Born in Manitoba, Miss Hibbert is a graduate of the General Hospital, Winnipeg, class of '37. In 1944 she obtained her certificate in teaching and supervision from the University of Manitoba; in 1953, her B.Sc. in administration of nursing services from Teachers College, Columbia University, and in 1957, her M.A. in administration of nursing education from the same institution. This past year she completed the requirements for a professional diploma in graduate nurse education at Teachers College after receiving a Kellogg fellowship.

Miss Hibbert has had considerable practi-

DOROTHY MAUD HIBBERT

cal experience in nursing service administration. Shortly after graduation she joined the staff of her hospital as a general duty nurse, later becoming a head nurse — a position that she filled for several years. In 1948 she was appointed an instructor and supervisor in surgical nursing and in 1950 she became the director of nursing services at W.G.H. Miss Hibbert was a member of the board of managers of the MARN for approximately five years, interrupting her term of office briefly for postgraduate study. In addition she was a member of the nursing service committee of the district association for two years.

In her leisure time, she enjoys her membership in the Soroptomist Club, the University Women's Club and similar organizations, and helps in the work of the Women's Auxiliary of her church. Stamp collecting, handwork and gardening, "all in moderation," help to fill any spare moments.

After 30 years of service with the Victorian Order of Nurses for Canada, **Dorothy Fowler** has retired.

(The Smith Studio—Amherst)

DOROTHY FOWLER

A Maritimer by birth, she took her professional training at Newton Hospital in Newton Lower Falls, Massachusetts. This was followed by postgraduate study in public health nursing at Columbia University. Miss Fowler first joined the V.O.N. in 1928 after experience as a staff nurse at Highland View Hospital, Amherst, N.S. and in public health nursing south of the border in West Virginia.

She began her career with the V.O.N. as a staff nurse in Halifax and over the years she has been nurse-in-charge of branches in Kentville, Sydney and Sackville, Nova Scotia and Moncton, New Brunswick. In 1953 Miss Fowler was appointed the regional director for Nova Scotia and Newfoundland. A sense of humor, an immense fund of energy and her interest in her work carried her through a regime of constant travel and work, especially during the years since her appointment as regional director, that would have exhausted many. Everywhere she went, she made friends for herself and the organization that she has so ably represented. Her retirement will be regretted by her colleagues, friends and patients but the good wishes of all are extended to her for her future happiness.

ANNONCIADE BERGERON

Annonciade (Martineau) Bergeron retired from her position as chief nurse in the City Health Department of Montreal in October, 1958. The loss of her services in public health nursing will be felt keenly but freedom from professional duties has made it possible for Mrs. Bergeron to enjoy her new home in Shawinigan, P.Q. and her activities as a housewife.

Her interest in public health began shortly after her graduation from Montreal's Notre-Dame Hospital. After four years with the Brown Paper Company at La Tuque, she did postgraduate study at the University of Montreal. Some time later she spent a year at Teachers College, Columbia University.

Her association with the Montreal Department of Health began in 1928 when she was appointed supervisor in the division of communicable disease control. It was interrupted temporarily while she acted as interim director of Ecole d'Infirmières Hygiénistes

at the University of Montreal. She returned to the Department in 1942 where she subsequently served as assistant director and then director of nursing services.

The alumnae association of her hospital, the provincial Public Health Section, the CNA Public Health Section and the Canadian Public Health Association Nursing Section have all received her active support and energetic participation. She is a past president of the Association of Nurses of the Province of Quebec.

The sincere good wishes of her friends and former colleagues in the nursing profession are extended to Mrs. Bergeron for her future happiness.

In Memoriam

Annie Black who graduated from the Hamilton General Hospital in 1917, died in October, 1958. She had engaged in private nursing for a short time before illness forced her retirement at an early age.

* * *

Phyllis Margery Dart, a graduate of Guy's Hospital, London, England in 1917, died in Hamilton, Ont. on November 30, 1958. She served during World War I as a member of the Queen Alexandra Imperial Nursing Service in the Dardanelles, Egypt and South Africa. Miss Dart came to Hamilton in 1923 and joined the staff of the General Hospital as a head nurse. She retired in July, 1957 but continued to give part-time service until shortly before her death.

* * *

Gretta MacKay Ross, a graduate of the General Hospital, Toronto in 1919, died on December 12, 1958. She was in charge of the social service department of the Hospital for Sick Children, Toronto before going to Bedford College, London, Eng. where she took advanced study in public health nursing. On her return to Canada Miss Ross became the first Director of Nursing and Camps for the Ontario Society for Crippled Children. Three camps were opened under her supervision. She retired from this position in 1953.

GRETTA MACKAY ROSS

* * *

Catherine G. (Marshall) Hawkins died in August, 1958 in Hay River, N.W.T.

* * *

Kathleen (Stowzinski) Hopfner who graduated in 1956 from St. Boniface Hospital, Winnipeg died in Winnipeg in October, 1958. Mrs. Hopfner was on the staff of Johnson Memorial Hospital, Gimli, Man. at the time of her death.

* * *

Beatrice M. Knechtel, a staff member of the South Waterloo Memorial Hospital, Galt, Ont., died on November 3, 1958.

* * *

Joan (Nixon) Morrison who graduated from the General Hospital, Hamilton in 1951, died in June, 1958.

* * *

Gerald Roth who graduated from the General Hospital, Hamilton in 1942 died on March 23, 1958. After a short time spent in general duty at H.G.H. and St. Mary's Hospital, Kitchener, Mr. Roth joined the staff of the Freeport Sanatorium, Kitchener where he remained until his death. He was a member of the executive of the Ontario Male Nurses' Association.

* * *

Clare Waller who graduated from the General Hospital, Hamilton in 1911, died in August, 1958. She had engaged in private nursing until she retired in 1932.

If God be for us who can be against us.
— Holy Bible, Romans VIII.

She speaks, yet she says nothing.
— WM. SHAKESPEARE

The Past has a Future

ALBERT W. WEDGERY, REG.N.

THERE IS ONE QUESTION that I am asked frequently, both within and outside the profession, and for which, as a matter of defence, I have long since prepared an immediately reply: "Do you believe there is a future for men in nursing?" A ready affirmative on my part, supported by a few terse but emphatically stated reasons why I feel there are abundant possibilities for men in the nursing profession usually engenders a facial response which implies grave misgivings about my sanity. Whenever I encounter this anticipated unfavorable reaction, my only consolation is to remember that to most people (including many who should know better) the contemplation of a nursing career for a man seems illogical, if not downright fantastic. In the face of such undisguised mental opposition I have found that it is often much wiser to let the uninformed go their incredulous way rather than disperse one's energies on a not-always successful barrage of persuasion and enlightenment.

It is strangely ironic that this modern tendency to reject nursing as an appropriate and acceptable type of work for men reflects so closely the unfortunate position in which women found themselves less than a hundred years ago, if they dared to dream of nursing as a suitable occupation for their sex. One need only recall (with humor now) the wave of revulsion and hysteria that swept the family circle every time Florence Nightingale broached the matter of training as a nurse. Yet, when the long, bitter struggle against prejudice and ignorance had been won through Miss Nightingale's unceasing perseverance, nursing became so inseparably identified with women that a new professional concept slowly and inevitably took shape. Thus, what had at first appeared impractical and doomed to failure in the face of violent antagonism in official circles, proved in the end to be the redemption of thousands of women who sought in nursing a worthy and satisfying outlet for their talents and energies.

While it may not be entirely just to label Miss Nightingale's persistent campaign against Victorian sensibilities as an "accident of history," there is no gainsaying the fact that her ultimate victory has created the false impression in succeeding generations that nursing has always been an exclusively female vocation. Despite much historical evidence to refute this misguided belief, there has grown up in the public mind a far too ready acceptance of nursing as a type of work which can best be performed by women and in which men can have no valid interest. Consequently, many young men whose temperaments and abilities would make them valuable additions to the nursing profession find themselves out of line with the cultural patterns of our present century. In other words, where once public opinion had been, on the whole, unsympathetic to the notion of gentlewomen training as nurses, so now it continues to uphold a tradition and sentiment that have the dubious value of keeping the nursing profession almost restricted to female practitioners.

Essentially, then, the whole question of a brighter future for men in nursing in this country revolves around the established cultural beliefs and customs of the present day. Even in this remarkably progressive era of our civilization, owing to the prevailing sharp division between what are deemed conventional male and female occupations, it is sometimes risking social disapprobation to pursue any career that does not fit into the accepted mould. Oddly enough, though women have invaded many fields of work that a half century ago were acknowledged inaccessible citadels of masculine employment, there has been a surprising reluctance in many quarters to encourage men to

Mr. Wedgery is operating room supervisor at the General Hospital, Oshawa, Ontario.

seek careers in those areas that are commonly regarded uniquely female callings. Nevertheless, in those instances where men have crossed the imaginary barrier and found personal satisfaction and happiness in work that is orthodoxly considered female, they have often achieved conspicuous success and given undeniable proof that men are able to perform these duties equally as well as women.

Is it not time, then, to cast off the shackles of tradition that hinder nursing from realizing its full professional potentialities? Should we not discard these outworn impediments that have no rightful justification today and look the matter of recruiting more men into nursing squarely in the face? Once we can get a clear picture of the singular opportunity presented to the nursing profession to make possible worthwhile and permanent careers for young men, we shall perceive that the present disposition to retain outmoded sentiments would seem to place nursing in a somewhat static and unprogressive position.

At the present time the few men, comparatively speaking, who embark upon nursing careers in Canada are very much in the same circumstances as women who enter the medical and legal professions. In both situations these individuals, who feel a distinct call to their respective fields and are brave enough to risk being thought eccentric and noncomformist, (although this is less true today in the case of female doctors) pursue their vocations vastly outnumbered by members of the opposite sex working in the same professional territory. Furthermore, in each instance, until they have proved themselves capable and reliable practitioners in a new environment, there is often an unwitting inclination on the part of their coworkers to look upon them as curiosities, or at best, misfits. If this seems too severe an appraisal of the predicament facing these dedicated men and women, I think you will agree, at least, that while there appears to be a great deal more reciprocity nowadays in these virtually restricted occupations (teaching has long been the notable exception in this regard), there is still enough adverse sentiment of this kind tainting these respected professions to cause discomfort and diffidence in those determined souls who encroach upon the hallowed precincts.

Therefore, anyone who approaches the matter of recruiting more men into the profession, with a realistic appreciation of the difficulties of such a task, will be faced with the immediate problem of convincing the general public, and the male portion in particular, that nursing is not an effeminate and unnatural vocation for men. For one thing, history reminds us that the military orders, which were founded during the Middle Ages to care for the sick and needy, were comprised solely of men trained specifically for this philanthropic purpose. It is especially worth remembering, too, that the institution of chivalrous virtues such as obedience, discipline, and devotion to duty by these Knights Hospitallers have become an integral part of our nursing legacy from a faraway time when the burden of caring for suffering humanity fell equally upon the shoulders of both men and women. If contemporary proof is needed for the process of re-educating the public one need only consult the present record for ample confirmation that men are making, and will continue to make, a distinctive contribution to the nursing profession. Across Canada in general hospitals, in schools of nursing, in mental and penal institutions, in the public health field, and in industry, men are now occupying important positions as directors, supervisors, instructors, and head nurses, in addition to others who are employed as general staff nurses. In those places where men are supervising and directing staffs comprised of one or both sexes there prevails, more often than not, a wholesome atmosphere of efficiency and cooperation that is sometimes lacking in situations where feminine leadership is not always able to cope with problems of incompetence and insubordination. Moreover, it has been proved that there is unquestionable value in having men in such administrative posts because their uninterrupted careers as nurses produce a long-range employment that effects a stabilizing influence within the profession itself.

It is, I suggest, this necessary element of stability which more men in

its ranks could give to the nursing profession. This appears to be the cardinal feature of recruiting them into this sphere of work. To intelligent and far-sighted young men, with a genuine calling to this field, nursing could become a lifetime occupation in which they would find satisfying rewards and the proper incentives to grow professionally. To many young women, on the other hand, nursing is a valuable and treasured steppingstone to marriage, a home, and a family, a commendable ambition which few will dispute but an objective that annually robs the profession of hundreds of trained personnel. In spite of the great numbers of women who graduate from our schools of nursing each year, there is no alleviation of the now chronic shortage of nurses, an apparently irremediable situation that gives every indication of becoming more acute as hospital services expand. Even if only small groups of men were turned out each year, they would help in some way to fill the gap left by those nurses who desert their vocation, for it is conversely true that marriage and domestic responsibilities, providing remuneration is adequate, would not have the same effect on their budding careers. Thus, there is every reason to hope that large numbers of men, who could have a stabilizing and salutary influence on the profession, would help to establish a firmer foundation for Canadian nursing as it explores new pathways in service and education.

Notwithstanding these pertinent possibilities, however, it must be remembered that if nursing is to attract its share of ttalent among young men (and women) it must expect constant and vigorous competition from other occupations, especially in regard to monetary returns. Nowadays, with few exceptions, recrultment into any type of work is influenced by remuneration and terms of employment, two basic points that may well spell the answer to the chronic inability of the profession to overcome the present shortage of graduate nursing personnel. No matter how sincerely a man may want to become a nurse, he is not likely to endure a long period of training (unless there is a personal reason for doing so) if the rewards and opportunities at graduation are not equal to other occupations demanding no apprenticeship and less responsibility. While present salaries show a striking improvement over those of the immediate post-war years, nursing must not relinquish its constant struggle to bring its pecuniary compensations more into line with other professional groups. In short, if nursing hopes to meet fully its expanding obligations, it must make every effort to retain adequate numbers of trained personnel by assuring them of truly professional benefits.

All the same, there are small but obvious signs that the men in nursing today are enjoying the gradual but welcome recognition of the special role which they can play in professional affairs and activities. As every year sees an increase in the number of male nurses who have come to this country from Great Britain and Europe to seek a new livelihood and a new professional outlook, it is not unreasonable to expect these men to want some share in formulating the plans and policies of nursing in their respective communities. In Ontario, which boasts the first committee of male nurses in the history of Canadian nursing, it is heartening to report that men are now sitting as members of the permanent committees of the Registered Nurses' Association of Ontario. Each year at the annual meeting of that organization the registration of men has increased to the point where what was once virtually a sea of feminine faces has now become pock-marked with small spots of masculine invaders equally intent upon the proceedings.

An even more important move in this direction has taken place recently in Nova Scotia where a man has been appointed chairman of one of the main committees of the provincial nursing association — a forward step which shows not only enterprise but also faith in the future contribution that men can make to their calling. It is, I believe, indicative of a *realistic* trend of thought in provincial nursing affairs that in the brochure, "A New Day," which was prepared for the opening of the new headquarters of the R.N.A.O., the following significant statement appears:

> in it will work, and in it will study, the men and women who are dedicated to the

raising of standards of nursing education and service.

Ten years ago, perhaps even five, this confident assertion would have been unthinkable so little part did men take in nursing activities. Today, it opens not only a new door to the future for men in nursing in Ontario but also serves as a guide to other provinces where men may be waiting and eager to share in shaping the course of their profession.

Does it seem strange to you now that I remain steadfast in my belief that few other professional fields offer better opportunities to the right men than nursing does today? In what other field at the moment does there exist such an alarming shortage of trained personnel with the likelihood that the inception of government-sponsored hospital insurance schemes will create an even greater demand for competent practitioners? All in all, there are unlimited possibilities in the variety of available positions, each of which will depend upon personal interest, initiative, and proficiency. Furthermore, it is clearly evident that nursing is taking the necessary steps to raise its financial position from the present uninspiring level so that it can compete more favorably with other professional and non-professional occupations. If this happy objective is reached in the near future, there is no logical reason why men should not find in nursing all the essential attractive conditions for security and advancement.

Today, while fundamental and often revolutionary changes are taking place within nursing that will set the pattern for future developments, there is no better time for rededication to the cherished ideals of our highly-respected profession. It is an excellent time, also, for re-evaluation of the methods and devices employed to recruit personnel so that every potential candidate for training, male or female, will not fail to find in nursing those professional and personal rewards that are the hallmarks of a worthwhile vocation.

Lastly, it is an opportune time for a renewal of purpose throughout the profession, for a broadening of our professional horizon so that, side by side, men and women can share in the steady progress of nursing as it strides forward confidently to meet the unforeseeable problems of this challenging century.

Greetings from the ICN President

In extending my good wishes to nurses throughout the world, I am reminded that in most countries this is a season for giving and receiving gifts. As nurses, we treasure our privilege of "giving" generously to those for whom we care. May we strive for increasing wisdom to give with such understanding and compassion that the receiving of our gifts will bring comfort and joy as well as improved health.

To achieve our goals we need to work closely with all of our colleagues in the health team and to develop an understanding of the general public. For this we shall need the help and the facilities of our national nurses' associations.

Through this greeting I send my good wishes to our member organizations and to each of the nurses whom they represent. I am confident that by giving strong support to your association in the coming year you will *give* more effectively to the patients and the community, and the citizens will continue to *receive* richly throughout this year, and the years to come.

Affectionate greetings to each member for an active and eventful 1959.

AGNES OHLSON
President
International Council of Nurses.

Peptic ulcer tends to be worse in the period from October to March. During these months there is usually less opportunity to follow outdoor interests and to relax from the day-to-day grind . . . People do not seem to have the feeling of well-being that they have in the sunny months of the year . . . There is a psychogenic factor involved in the formation of peptic ulcer and any condition that affects the individual's feeling of well-being will have an effect on ulcer symptoms. — *American Journal of Nursing*

RESEARCH

The Master Plan of Rotation

MARGARET M. STREET, B.A.

(Concluded from the January 1959 issue.)

ADMINISTRATION OF THE PLAN

1. *Postings*: From the Master Plans of Rotation for all classes, postings may be made once monthly, or as deemed advisable. For example, at the end of November, 1958, postings may be made for the months of January and February, 1959 or for one month only, if preferred.

Mimeographed copies of the postings for all wards and departments will then be sent to head nurses, supervisors, clinical instructors, the nurses' residence, the associate directors of nursing education and nursing service, the student health service.

2. *Program revisions* for individual students may become necessary through illnesses, leaves of absence, etc. These are made on an individual basis, according to the particular circumstances of the case. Generally speaking, it is advisable for the student, after the initial adjustment of program, to carry on with her rotations according to the original plan. However, this may not be advisable, in which case more complete readjustment of program must be made. Everyone concerned must be advised of any changes in postings which have been made. This is probably best done by memoranda, rather than by telephone.

3. *Use of Master Plan by clinical instructors* for all classes, is a helpful tool in assessing the learning needs of the individual student, and in planning her ward teaching program in advance of her coming to the ward. The instructor can see at a glance what previous experiences and classes the student has had, whether she will be returning at a later date to this same service, and, if so, when. She is alerted to the special needs of the student arising out of her background of experience and instruction. For instance, a young intermediate student, entering a general surgical ward, may have had the following experiences between the time she finished the Medical-Surgical Block, in May, and the time she enters general surgery: holidays, four weeks; central supply room, two weeks; diet kitchen, six weeks; operating room, eight weeks; and general medicine, four weeks. She has had very little bedside nursing experience since the block, and will require careful guidance and supervision in nursing care, in the administration of medications, etc. The clinical instructor then has the responsibility of advising the head nurse, team leaders and other staff regarding the background of this student and her special needs.

A clinical instructor in medical nursing, consulting the Master Plan in advance of a student's coming to the ward, will be able to ascertain how much experience of this kind the student has had, and how much she will have later. This, in turn, makes it possible for her to plan a program for the student at the level she has reached.

It should be noted that the clinical instructors — in seeking information about the background of the

Miss Street is Associate Director of Nursing of the Calgary General Hospital School of Nursing.

student and her progress to date — will wish to consult, also, the Clinical Experience Monthly Record Book, and the Clinical Progress File of the student. It is helpful if these sources of information are all kept in one office, that of the Clinical Coordinator or person doing the rotations.

4. *Withdrawals* constitute a problem of greater or lesser magnitude, in administration of the Master Plan, depending upon the number, and where they fall on the plan. Generally speaking, it is advisable to adhere to the original plan. This is possible only in a situation where stabilization of the service is not dependent upon student nurse service. *Stabilization of service by general staff nurses and nursing aides is vital to the successful administration of the Master Plan and of the educational program as a whole.*

5. *A major principle* of first importance in the administration of the Master Plan is that students are not moved for service needs from the area to which they have been posted to another area where there may be a shortage of staff. Graduates or nursing aides may be moved, to stabilize service needs, but not students, otherwise the educational program of the student is seriously disrupted.

6. If curriculum revisions in the educational program for a particular class should be deemed essential — and major revisions of a program once planned should be relatively few — this may necessitate redrawing the Master Plan, which is a very difficult matter. It seems advisable to hold firmly to the curriculum pattern established for any one class, and to undertake revisions for succeeding classes instead. However, it is inadvisable to hold to a pattern which experience has revealed to be faulty, and revision of the Master Plan to make possible the correction of weaknesses appears justifiable.

7. The Master Plan is *reviewed* thoroughly at the end of the second year.

Evaluation of the Master Plan

The final test of the Master Plan is the progressive development of the student in the program, and thus the satisfactory achievement of the aims of the educational program. Evaluation of the Master Plan of Rotation, as of other aspects of the total curriculum, may be made

a. By the *faculty* of the school of nursing, who are guiding the learning process and closely observing the student at every stage of her progress. Such evaluation should be a constant activity in the regular faculty meetings, which are attended by all instructors, classroom and clinical.

b. By the *head nurses*, and *supervisors* who have an important share in the clinical program of students, the assignment to them of patient care and related duties, supervision of such activities, and evaluation of the students. As custodians of patient care, head nurses are in a unique position to guide and evaluate students.

c. By the *students* themselves. It is helpful to receive the evaluation of students about their program, including clinical experiences. Students may give such evaluations in conferences with clinical instructors, with the clinical coordinator, the associate director of nursing education, etc. They may also be invited to attend meetings of the faculty for the purpose of making recommendations regarding their program.

d. The *quality of patient care* given by students and graduates of the school is the most sensitive index of the educational program, and of the rotation plan that is such an important part of it.

e. The *satisfaction of patients*, their relatives and doctors, with nursing care given.

Implications for the Nursing Service

1. *Estimating, for budget purposes, equated student service hours of coming fiscal year*: The Master Plans of Rotation are planned around the learning needs of the students, not around the meeting of nursing service needs. However, it must be recognized in the hospital school of nursing, that the student gives some service in return for her education. Until schools of nursing are established on a sound financial basis, like other institutions of learning, and until student nurses pay fees, like other students, we shall

have with us a situation where student nurse services are rendered in exchange for their education. However, it is essential, if we are to produce nurses capable of meeting the complex demands of today's program of total health care, that buffers be placed in the ward situation to protect both the care of patients and the learning needs of students. These buffers are general staff nurses and auxiliaries — certified nursing aides, and orderlies. The budget of the Department of Nursing should make provision for the required personnel.

2. *Nursing care is measurable in terms of hours per patient day*: The number of average hours of care in a given service of a particular hospital depends upon a variety of factors.

a. The physical plant and facilities of the ward and of the hospital.

b. Services rendered by other departments in the total care of patients.

c. Age of patients.

d. Diagnoses of patients.

e. Plan of medical care (kinds and numbers of treatments ordered, medications, etc.)

f. Plan of nursing care (custodial, rehabilitative, etc.)

g. Length of hospital stay.

h. Prognosis.

i. Presence of learners in the area (student nurses, medical students, etc.)

j. Research activities undertaken.

It appears necessary to establish, for each ward or service, a standard of patient care, including a statement as to the average number of hours to be given per patient day, and the percentage of these which will be given by professional and by non-professional personnel.

It is also necessary that a *record be kept, month by month, of the patient days in each ward.* This is used in forecasting staffing needs for the coming budget year.

Estimating the staffing requirements for a specific ward, for a given budget period, becomes a matter of exact computation, when one is in possession of the foregoing particulars, and in addition, information regarding the amount of student nurse service which will be available, equated in terms of professional or graduate nurse service.

In a moment, we shall consider one method of computing the amount of anticipated student nurse service, but first let us see how this information may be used, once we have secured it.

Example: West 5 is a general medical and diabetic ward, having both male and female patients in public (four-bed and six-bed), semi-private and private accommodations. Number of patient days for the last twelve-month period (September 1, 1957 — August 31, 1958) was 14,569. This figure will be used for budget estimations for the 1959 budget year. The standard of care approved for this ward is 3.4 hours, of which 65% is to be given by professional personnel and 35% by non-professional personnel. Graduate nurses work 1868 hours at the bedside in one year, and nursing aides 1891 hours. From the Master Plans of Rotation, it has been computed that student nurses will spend 13,839 hours at the bedside, equated in terms of professional (graduate) hours. How many general staff nurses and nursing aides will be required?

Total nursing hours required for 14,569 patient days, at 3.4 per patient day (3.4 x 14,569) = 49,534.6

Number of professional nursing hours (65% x 49,534.6 = 32,197.49

Number of non-professional nursing hours (35% x 49,534.6) = 17,337.1

Number of student (equated) hours anticipated = 13,839

Number of nursing hours to be given by general staff nurses (32,197.49 — 13,839) = 18,358.49

1868 nursing hours are worked by *one* general staff nurse in one year.

18,358.49 hours are worked by (18,358.49 ÷ 1868) general staff nurses = 9.8 (9 — 10)

1891 nursing hours are worked by one nursing aide in one year.

17,337.1 hours are worked by (17,337.1 ÷ 1891) nursing aides. = 9.1 (9)

Budget computations, may, with great advantage, be worked out on a four-month basis rather than a yearly basis. Such a method will provide for stabilization of service in periods of heavy class schedules, heavy holidays, or graduation, of a large class.

One Method of estimating available student nurse service:

1. From the Master Plans of Rotation, the anticipated numbers of students in all classes for the coming fiscal year are summarized.

2. Number of student weeks in each

clinical area is ascertained, both on the annual basis, and on the basis of four-month periods.

3. The summary of students of all classes anticipated in each ward weekly during the coming year is typed, and copies are made available to the clinical instructors, head nurses, and the associate director of nursing service. This summary is of great value in such aspects of administration as planning staff holidays, vacations of clinical instructors, etc.

4. *Student service hours* are computed from student weeks, as follows:

Example: Number of equated student service hours for Class 1959 (Senior), January-April, 1959.

Total service weeks, estimated January-April: 33 weeks, or 231 days.

Total maximum service days, exclusive of weekly day off (6/7 x 231) 198 days

Sick time to be deducted (7/365 x 231) 4 days

Statutory holiday time to be deducted (3 x ½ days) 1.5 days.

Net days of student service (198 — 4 sick days — 1.5 statutory holidays) 192.5 days

Total *hours* of duty (8 x 192.5) 1540 hours

Estimated teaching time deductible (33 weeks x 3 hours per week) 99 hours

Net hours of senior student service, January-April (1540-99) 1441 hours

Effectiveness factor of senior students 90%

Replacement value of students during this period (90% x 1441) *1297 graduate equivalent hours*

Similar computations can be made for the other classes of students using the effectiveness factors noted above.

It has been found advisable, when computing service hours of the junior class, to allow for a 15% withdrawal. This is done at the beginning of the computation, that is, the anticipated student weeks are brought to days, then 15% is deducted therefrom. This is a protection to the nursing service, since additional staff will be engaged as a buffer against withdrawals.

Conclusion

From our experience, the Master Plan of Rotation has proved to be an effective instrument in providing a balanced program of clinical experience, correlated with instruction, to all students. It has made it possible to provide all students of the same class with comparable experiences. Students have expressed satisfaction that they know in advance their program as planned for the three-year period. They are pleased, too, to be able to express certain preferences with regard to clinical experiences (including affiliations) early in their first year (before the names are put onto the Master Plan) and early in the third year when the total program is reviewed with each student, electives assigned, and, when indicated, certain revisions made in the third-year program.

Once the Master Plan has been constructed, which takes one or two weeks once yearly, administration of it is not difficult. Monthly postings take from one to two days. The balance of the month may be spent in other activities, apart from the small amount of time occupied by making minor day-to-day adjustments in an individual student's program.

From the point of view of nursing service, it has proved to be a valuable asset, in estimating staffing requirements for a budget period, to be supplied in advance, by the faculty member in charge of rotations, with a summary statement of the anticipated student inflow into all clinical areas for the coming year, and the graduate-equivalent hours of nursing service which are expected in them.

One out every 100 Canadians is a diabetic; five out of each 100 over 50 years of age have the condition. Forty per cent of diabetics are aware that they have it. Those who are over 40 years of age, overweight and have a history of diabetes in the family are most susceptible. Periodic medical examinations will aid in discovering the condition and permitting treatment to control it.

— Dept. of National Health and Welfare

The first entry of a member of Parliament with two Christian names occurred in 1552 — Thomas Maria Wingfield, Huntingdon, England.

L'Organisation et la Conduite d'une Assemblée

Patricia Duplain

Les horizons de l'hygiéniste ne sont plus exclusivement limités aux exigences locales, mais ils sont souvent ralliés aux besoins régionaux, provinciaux, nationaux et parfois même internationaux. Avec l'expansion toujours grandissante des services d'hygiène publique, les transformations démocratiques qu'ils ont subies dans les dernières années et les demandes croissantes du public, les hygiénistes — médecins, infirmières, inspecteurs et autres — sont souvent appelé à présider ou préparer une assemblée, intéressant le domaine professionnel ou extra professionnel.

Il est inutile d'insister sur l'importance capitale de la connaissance des divers médiums de communication avec le grand public et des mesures scientifiques qui doivent être utilisées pour obtenir pleine efficacité. Il ne s'agit pas de s'enliser dans une longue dissertation doctorale, mais pour arriver à un résultat satisfaisant certaines notions élémentaires doivent nous être familières, car il arrive souvent que le parrain d'une bonne cause en compromette le succès par ignorance des règles, d'usage, alors qu'un adversaire plus habile et plus au courant des technicalités en aura facilement raison.

D'après les concepts modernes, une assemblée est le résultat de développements techniques requérant un art et une préparation spéciale, convergeant vers les exigences de la communauté. Elle doit être efficace et comporter un travail d'équipe et plus l'assemblée aura d'envergure, plus grande sera l'équipe et aussi plus difficile sera la coordination.

L'homme étant un être éminemment social, a constaté depuis longtemps, qu'au contact de ses semblables, il enrichissait sa culture et son développement, par une association ou un échange d'idées. Les plus anciens registres du monde nous décrivent des réunions, soit pour fêter un chasseur victorieux ou pour organiser une stratégie de guerre. Il est même facile d'imaginer que l'homme des cavernes devait réunir son conseil autour du "feu de camp" pour discuter de ses problèmes.

De temps immémorable, la discussion a semblé être le dénouement heureux de la plupart des assemblées délibérantes. Par sa forme démocratique d'approche aux intérêts et affaires de la communauté, elle est une source inépuisable d'informations et les gens y participent ordinairement avec beaucoup d'enthousiasme. Poston déclarait dans "Small Town Renaissance," que la discussion franche et amicale par les gens eux-mêmes est le plus court chemin pour atteindre leurs problèmes et qu'aussi longtemps qu'ils pourront discuter librement, la démocratie survivra. Je crois qu'il est à propos de faire ici une courte revue des diverses méthodes de discussion les plus employées:

Parlons d'abord de l'*entrevue,* qui est ce contact individuel entre deux personnes se réunissant dans un but spécifique et bien déterminé. Forme d'approche intime et très personnelle, l'entrevue tend à renseigner l'un et l'autre des participants. C'est une méthode idéale d'éducation individuelle.

Vient ensuite la *conférence table ronde* où trois ou quatre personnes, parfois plus, sont réunies pour disséquer un ou plusieurs sujets d'intérêt commun. Un président choisi parmi le groupe est responsable de la discussion, il y participe s'il le désire, comme les autres membres. Il n'y a pas d'auditoire, l'atmosphère est familial et sans formalité. C'est un moyen efficace de renseignement pour un petit groupe d'une organisation et la formule généralement employée pour les réunions de comité.

Très populaire chez les anciens Grecs, le *symposium* consiste dans la présentation individuelle d'un sujet, par deux ou plusieurs experts, sous la direction d'un président. Le sujet, débattu pendant

Séminar présenté par Mlle Patricia Duplain sous la direction de Mlle Gabrielle Charbonneau, professeur à l'Ecole d'Hygiène de l'Université de Montréal.

environ dix à quinze minutes par chacun des experts, a pour but de présenter un problème sous plusieurs points de vue. Après quoi, l'auditoire peut énoncer ses idées et poser des questions. Cette méthode de discussion est constante et flexible dans sa forme et sa haute valeur a été reconnue dans le domaine de l'éducation publique.

Suit de près le *forum*, prenant forme de conférence un travail est élaboré par un expert et des questions, posées par l'auditoire, sont dirigées vers les spécialistes participant sous la tutelle d'un président. Il est avantageusement employé quand une information est désirée sur un sujet sans controverse et qu'on recherche les idées d'experts.

Le *panel* est une autre méthode très en usage de nos jours. Il se compose ordinairement de trois ou quatre membres tenant conversation devant un auditoire. Le président au centre, sans prendre part active à la discussion, la dirige et la clarifie au besoin. Le panel est surtout employé devant une assistance très nombreuse pour reproduire un point déjà discuté devant un petit groupe. La télévision en a fait un de ses spectacles éducatifs.

Tel que vous le connaissez, le *séminar* est la combinaison de recherche individuelle et de discussion de groupe. L'autorité décide du sujet à élaborer, un membre ou étudiant fait l'investigation et présente un rapport sur la question en cause. Il s'ensuit une discussion coopérative sous l'égide d'un professeur. Tous les étudiants doivent se renseigner sur la matière et prendre part à la discussion. Les universités et les centres de recherches l'utilisent sur une haute échelle.

Enfin l'*institut, cercle d'étude ou "workshop,"* présente une opportunité pour les individus de travailler ensemble à la solution de leurs problèmes. Il peut durer un seul jour ou s'étendre à plusieurs semaines. Le workshop organisé dans certaines universités devient véritablement un cours de "rafraîchissement." Des conférences prennent place dans l'avant-midi et l'après-midi, des petits groupes ayant un intérêt commun travaillent à l'analyse d'un sujet, un rapport est rédigé et présenté au groupe entier à la fin du "workshop."

De ces méthodes de discussion, le *symposium* et le *forum* sont souvent employés au cours des assemblées professionnelles ou autres.

Une simple réunion nécessitera moins d'élaboration qu'une convention de trois jours avec mille délégués venus de toutes les parties du monde. Mais qu'il s'agisse de l'organisation du plus petit cercle d'infirmières au plus solennel conclave, une assemblée pour qu'elle puisse délibérer validement doit être régie selon certains principes des procédures parlementaires, être orientée et dirigée par un chef aidé d'un exécutif qui en fera fonctionner le rouage effectivement et c'est ici qu'entre en jeu le choix des officiers.

Une organisation ne vaut que par le caractère et les aptitudes de ceux qui la dirigent, aussi faut-il apporter beaucoup de sagesse et de discernement dans la sélection des membres. Un bon comité doit être varié dans ses membres. Les uns, portant à l'oeuvre un intérêt très sincère, constituent des collaborateurs fort actifs, ils assistent régulièrement aux séances, donnent largement de leur temps et s'initient aux détails du fonctionnement. Ils portent sur leurs épaules le poids de l'entreprise. D'autres, ne pouvant donner un effort aussi continu, apportent tout de même le concours précieux de leur compétence technique. Enfin, certains ayant une valeur potentielle plutôt que réelle sont trop jeunes et trop inexpérimentés pour fournir une aide effective, ils sont les administrateurs de demain qui se forment au contact de leurs aînés. Leur présence est indispensable, car si brillant que soit le présent, il faut penser à l'avenir et l'attachement à une oeuvre ne s'improvise pas.

L'équipe sera aussi structurée par une variété d'âge et de sexe. Sans porter atteinte au prestige indiscutable du sexe fort, il serait parfois souhaitable que l'élément féminin y soit représenté, car sur le plan psychologique la femme, par sa nature et son éducation, perçoit ou conçoit les choses de façon différente et complémentaire à l'homme.

Toute prépondérance de classe sociale et de quartier doit aussi être évitée. On ne peut négliger l'influence attachée à la position sociale, mais la campagne entreprise pour la santé publique ne doit pas être l'apanage d'une coterie locale. Si désirable que soit la collaboration de chacune des personnes composant l'équipe, il sera sage

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à l'occasion de sacrifier le concours de certaines d'entre elles et de s'assurer une représentation équilibrée de tous les éléments de la population. Les circonstances extérieures ne doivent pas être l'unique critère de cet équilibre. Il faut dans un comité et des coeurs et des esprits, et les deux ne se rencontrent pas nécessairement dans le même individu.

Le minimum de personnes dans un comité doit comprendre un président, un vice-président, un secrétaire et un trésorier. On peut, selon les besoins de la cause, y ajouter un président honoraire, un ou deux vice-présidents, un secrétaire archiviste, un trésorier adjoint et des conseillers, avec un maximum limité de 15 à 20 membres, donnant la préférence à un nombre impair. Ce groupe constitue le bureau de direction ou l'exécutif selon le cas.

Dans le choix du président, trois points sont à considérer: l'expérience, l'habileté et le tempérament. Il doit être dynamique, versatile, posséder le sens de l'humour et des qualités de "chef." Son expérience des hommes le rendra capable de s'entourer de collaborateurs compétents. Son esprit sera assez ouvert pour accueillir les idées nouvelles. Si, à ces qualités s'ajoutent le prestige et l'influence conférés par un rang éclatant dans la société, dans les affaires ou dans une profession libérale, le choix n'en sera que meilleur, car il est le cerveau de l'assemblée, *"Autant vaut le président, autant vaut l'assemblée."*

Parmi les aspirants à la présidence, il nous sera donné de voir évoluer divers individus à personalités différentes; nous en étudierons quatre genres fréquemment rencontrés, à savoir:

Le type *phallique, policier ou dominateur,* il domine s'impose au groupe sans toutefois obtenir la collaboration ou la sympathie des membres. Une fois élu, il attache beaucoup d'importance à son titre et aux honneurs qui en découlent. Avec un tel président, l'organisation aura à souffrir.

Le type *obsessif* se sent en conscience le seul à pouvoir tout faire, il ne délègue aucune responsabilité à personne. Il apporte grand soin à une multitude de détails, néglige les grandes lignes et perd de vue l'essentiel. Une fois élu, il cherche constamment l'approbation. Avec un tel président, qu'adviendra-t-il?

Le type *passif* réunit tous les membres, les laisse sans directive et croit que tous pourront réussir par eux-mêmes. Alors, une fois élu, qui dirigera l'entreprise?

Enfin de type *actif* n'est pas autocrate. Il stimule les gens, les encourage à se mettre d'accord, à former un groupe, à donner leurs opinions et à coopérer activement aux décisions du groupe. Une fois élu, il sera le *président ideal!*

Après cette brève énumération, libres sont les gens de faire un choix judicieux de leur président, car par son rôle, il dirige les délibérations, maintient l'ordre et le décorum, reçoit les propositions et les soumet à l'assemblée, se prononce sur les questions de procédures, appelle le vote et proclame les résultats, signe les documents officiels, confirme les procès-verbaux des séances antérieures approuvés par l'assemblée. Il ne prend part à aucune décision et ne vote qu'au cas d'égalité des voix, alors qu'il a prépondérance.

Si le président désire prendre part à un débat, il doit laisser le fauteuil et y appeler le vice-président ou à défaut un autre membre à présider, mais il doit s'abstenir autant que possible de recourir à cette méthode, afin de conserver son prestige d'impartialité. En cas d'appel de sa décision, il a droit d'être entendu le premier sur les dits motifs, sans être obligé de laisser le fauteuil. Il reste assis pour disposer de la routine, mais il doit se lever pour énoncer les propositions et pour en appeler le vote.

Quel rôle assigne-t-on au vice-président? Il remplit les fonctions du président en l'absence de celui-ci; il est souvent appelé à présider les réunions de l'assemblée lorsque celle-ci siège en comité plénier. La vice-prédence est trop souvent considérée comme un poste purement honorifique et cette attitude présente de grands inconvénients. Le progrès d'une oeuvre est maintes fois paralysé à cause d'un officier incapable d'assumer, le moment venu, les responsabilités que le président abandonne temporairement. Les qualités personnelles du vice-président peuvent bien se comparer à celles du président.

Quelle est la fonction du secrétaire? Il envoie les avis de convocation, prépare l'ordre du jour et

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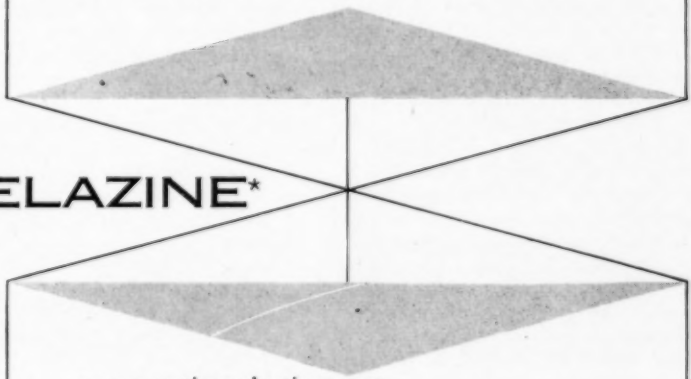

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communique aux membres les rapports des comités, les motions et autres documents officiels dont il a la charge. A chacune des séances il rédige et signe les procès-verbaux qu'il soumet à l'approbation de l'assemblée. Le président les confirme de sa signature en indiquant la date de cette confirmation.

La bonne administration du conseil dépend beaucoup plus qu'on ne le pense de sa compétence et la tâche du président se trouve considérablement facilitée, s'il a comme secrétaire une personne sur laquelle il peut se reposer pour tous les détails du service. Si l'assemblée se réunissait sans qu'il y ait de président ou de vice-président, il est du devoir du secrétaire de l'appeler à l'ordre et de provoquer l'élection d'un président provisoire.

Pour que l'assemblée soit validement constituée et conforme aux statuts exigeant la présence d'un nombre déterminé de personnes, il faut s'assurer avant l'ouverture qu'il y a "quorum" pendant la durée des délibérations. Le secrétaire est ordinairement chargé de cette constatation.

Quant au trésorier, il s'occupe de la comptabilité, prépare et présente le rapport financier. Conjointement avec le président, il signe les chèques et autres documents concernant les finances de l'organisation. Ses responsabilités sont grandes et il doit parfois, dans l'exercice de sa charge, être couvert par une police d'assurance donnant une certaine garantie contre les erreurs ou détournements de fonds.

Il nous reste à considérer les droits et les devoirs des membres. Au cours d'une assemblée, les membres passent par différents stades avant de faire vraiment partie intégrale d'un même groupe. Cette évolution psychologique s'opère par différents phases dont la première appelée phase individuelle, est celle où chacun fonctionne comme individu et essaie de se faire accepter comme tel.

Dans la phase d'identification, les membres cherchent à faire paire, triangle ou chaine avec les autres membres de l'assemblée. Puis, processus analogue à celui qui se passe chez l'adolescent, alors que devient adulte, phase de narcissisme et de dévalorisation, les gens surestimés deviennent des statues d'argile et ceux que l'on mésestimaient sont appréciés à leur juste valeur.

Enfin, arrive la phase de stabilisation ou de productivité. Les participants s'acceptent bien comme différents et incomplets. Chacun apporte une bonne volonté à dépersonnaliser et à liquider ses conflits en face des exigences du travail demandé. Tel sera le comportement de l'équipe idéale.

S'il est un terrain ou la liberté d'opinion doit s'exercer dans toute sa plénitude, c'est bien celui d'une assemblée délibérante. Chaque membre a le droit de soumettre ses propositions ou motions et de les discuter sans qu'on puisse porter atteinte à l'exercice de ce droit, mais la liberté n'est pas synonyme de licence et celui qui veut exercer son droit ne peut le faire au préjudice de ses collègues.

Le premier droit des membres est bien celui de la liberté de parole. Après avoir dûment demandé la permission au président, le participant doit rester dans les bornes légitimes. Ainsi, on ne peut interrompre un membre qui a la parole, à moins que ce soit pour le rappeler à l'ordre ou pour établir une motion privilégiée, légalement admise. Les interruptions, les apostrophes, les conversations entre les membres ne sont pas de mise, surtout si elles ont pour effet de distraire l'attention de l'assemblée, et le président veillera à l'application rigoureuse de ces prescriptions.

L'assemblée légalement constituée doit donc être régie selon certains principes des procédures parlementaires. Ils ont pour but de faciliter et d'aider la transaction des affaires, tout en protégeant le droit des membres. Quelques-unes de ces lois sont essentiellement techniques et si elles ne sont pas comprises, elles peuvent donner lieu à la confusion plutôt qu'à la bonne entente.

Un premier principe veut que *la majorité ait force de loi.* La majorité dans une assemblée est souveraine et ses décisions ont forces de loi sauf en certains cas, où les principes du droit des gens sont établis si fermement, qu'il faut une proportion plus nombreuse et parfois même l'unanimité pour les ignorer. Par contre *la minorité doit aussi être entendue.* Ses droits de base doivent être reconnus et respectées; elle a droit d'entrer dans la discussion et de présenter son opposition en temps opportun.

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Un autre principe dit que *chaque motion présentée est sujette à libre et entière discussion.* Le proposeur fait l'éloge de la motion et en expose tous les mérites; de leur côté, les adversaires doivent avoir la même opportunité de formuler leur opposition. Cependant, il faut ne faire qu'une chose à la fois et si plusieurs motions étaient présentées en même temps, il en résulterait une anarchie complète. Le président veillera à l'observation de ce principe. Enfin il doit y avoir justice et courtoisie pour tous les membres présents. Ce principe ne s'applique pas seulement au président ou à ses officiers, car par son attitude de courtoisie et sa manière d'agir le président devient une saine inspiration pour tous les membres.

Qu'entend-on par motion? C'est une proposition faite par un membre de la réunion, c'est une forme de procédure des lois parlementaires requises pour la transaction des affaires dans un corps délibérant. Une motion peut être principale, privilégiée, subsidiaire ou incidente. Elle doit être présentée selon la procédure suivante:

> Un membre se lève et s'addressant au président, il s'identifie puis énonce la motion qui doit être secondée par un autre membre. Le président énonce la dite motion à l'assemblée et la discussion est ouverte, après quoi il prend le vote et annonce le résultat. L'amendement à une motion est une autre forme de procédure par laquelle un membre de l'assemblée propose une modification. On peut amender la motion par addition, insertion, élimination ou substitution.

La technique d'organisation immédiate, en vue de la tenue régulière d'une assemblée, demande de tracer un plan déterminant la date, l'heure, l'endroit, le sujet à être discuté, le conférencier à inviter s'il y a lieu. Il est à propos de rédiger un agenda et de le faire distribuer aux membres quelques jours avant l'assemblée, ainsi qu'à ceux qui prendront une part active à la réunion. La publicité est assurée par les moyens usuels de la presse, de la radio, des annonces au prône, des feuillets et des cartes d'invitation.

Le nombre et la nature des comités diffèrent suivant les besoins du service ou de l'organisation. Si un comité est nécessaire, il faut le créer, mais un petit nombre de comités travailleurs et vivants vaut mieux qu'un grand nombre plus ou moins actifs.

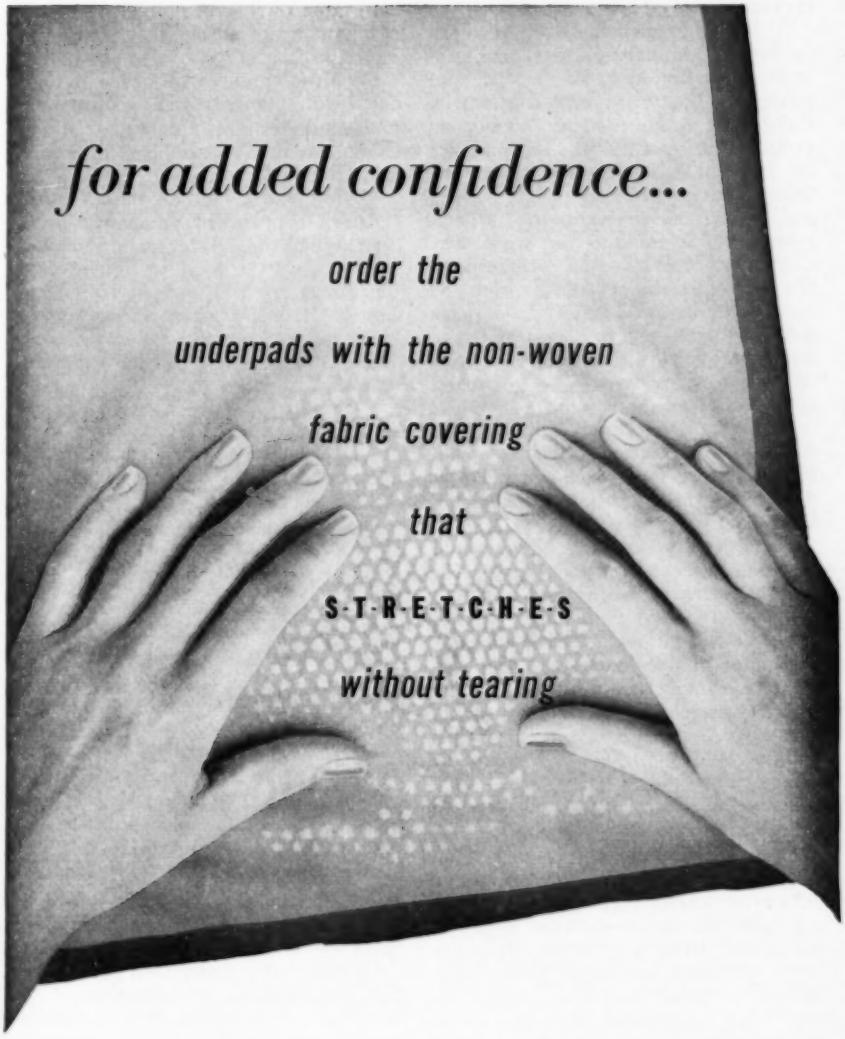
Avant d'approcher le conférencier, il est prudent de s'assurer que la date de la réunion ne coïncide pas avec un autre programme intéressant la majeure partie des gens de la localité. Dans une petite ville ce détail est vite éliminé, mais dans une plus grande il est bon de consulter qui de droit à ce sujet.

Le choix du conférencier est aussi d'extrême importance. Il ne sera ordinairement pas le même s'il s'agit d'une assemblée ordinaire, spéciale ou de l'inauguration d'une nouvelle technique comme d'un nouveau service. Quoiqu'il en soit, il doit être approché à l'avance et il est de bon aloi de lui offrir un cachet.

Quelles sont les obligations dues au conférencier? D'abord la courtoisie la plus raffinée depuis son arrivée dans votre localité, jusqu'aux derniers moments de son départ, impliquant ainsi un maximum de prévenances et d'égards. Trop de conférenciers ont été négligés dans le passé et tout habitué en la matière pourrait en relater de tristes expériences. Puis dès qu'il a accepté votre invitation le comité doit être informé des qualifications de ce personnage, de son rang social, de la fonction qu'il occupe, des services qu'il a rendus, selon le cas, pourquoi il est invité à parler et le rôle qu'il aura à jouer. Avec ces renseignements il sera plus facile, le moment venu et si l'occasion s'y prête, de converser plus librement et intelligemment avec lui.

Certaines organisations ont même l'initiative de réunir leurs membres spécifiquement dans le but de faire connaître leur conférencier. Une photographie, par exemple, pourrait aider à le faire reconnaître à première vue.

En lui écrivant ensuite pour le remercier, il convient de lui demander à quel moment précis il se propose d'arriver dans votre localité, quel moyen de transport il utilisera, de quel matériel il aura besoin, s'il sera accompagné, secrétaire ou associé, s'il a des amis dans la localité qu'il désire inviter, l'informant que ces personnes sont bienvenues à l'assemblée et que des prévisions seront faites à leur égard. Quand l'invité aura répondu à toutes ces questions le président verra à con-



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fier à un membre le devoir d'exécuter les désirs du conférencier, en temps opportun.

Si la séance coïncide avec un dîner ou banquet, le maître d'hôtel sera prévenu assez tôt. En lui faisant connaître le nombre de gens attendus il serait sage de lui envoyer l'agenda ou programme, cette marque de confiance est susceptible parfois de faire bénéficier d'un meilleur service. Un délégué responsable arrivera sur les lieux avant l'heure indiquée et verra aux derniers préparatifs de l'événement. S'il y a des billets d'admission ou cartes d'invitation à l'assemblée ou au dîner, et ceci est psychologiquement important à plusieurs points de vue, on doit s'assurer que le conférencier et les invités en sont pourvus.

Pendant les quelques minutes précédant la conférence, certains ont l'habitude de circuler avec le conférencier dans les différents groupes. Selon Mr. Donahue, expert reconnu en la matière, ce n'est pas une très bonne politique, car le conférencier a besoin de toute son énergie pour les heures qui suivront et il est de mauvaise psychologie de le faire parader dans une assistance qu'il essaiera tout à l'heure d'impressionner, une certaine distance est nécessaire à l'être humain payant un ultime hommage à l'inaccessible. Il est suggéré de garder le speaker dans une semi-retraite, il ne s'agit pas de le reléguer à l'écart, un membre, celui qui doit le présenter par exemple, profiterait fort bien d'un entretien avec lui.

Un conférencier a besoin d'une bonne présentation autant qu'un livre est favorisé par une bonne préface. La présentation a pour but de créer cette ambiance favorable lui permettant de présenter son message dans les meilleures conditions possibles. Elle doit réunir trois points et faire savoir qui est le conférencier, quelle est son histoire ou son statut et pourquoi il est invité. Elle doit être claire et précise, n'excédant pas plus de cinq minutes. Elle peut être faite par le président ou toute autre personne assignée à cet effet.

Si l'on doit avoir une période de questions et réponses, à la fin de l'assemblée, il est bon d'en discuter à l'avance avec l'invité, certains d'entre eux y excellent, d'autres s'y objectent, cette procédure peut donner de grands résultats, mais aussi récolter de malheureux échecs.

Avant la conférence, il est bon aussi de prévoir une entrevue avec les journalistes ou les messieurs de la radio et, s'ils assistent à l'assemblée, un endroit leur sera réservé.

Il faut aussi remercier le conférencier, le président ou le vice-président rempliront cette tâche; souvent certaines organisations assignent cette fonction à une personne de l'auditoire. Même si le conférencier n'a pas su soulever tout l'enthousiasme qu'on y attendait, il a droit à une certaine marque d'appréciation.

Le lendemain de la conférence, le secrétaire se charge d'écrire au conférencier pour le remercier chaleureusement. Il lui fera parvenir le cachet qui lui revient ainsi que les reportages de journaux concernant la publicité et la critique qu'il a eues.

Pour assurer aux assemblées tout l'éclat et le succès auxquels on aspire, il faut mettre beaucoup de dynamisme et un certain intérêt matériel de nature à éveiller ou attirer les gens de toutes classes et de toutes conditions. Il faut toujours se rappeler ce motto emprunté au monde théâtral: "Put on a good show."

Les gens qui assistaient à une réunion le font librement pour y être inspirés, amusés ou instruits; il est important de les considérer et de s'adresser à eux comme individus et non comme à une foule, il faut éviter les termes trop collectifs.

Conduire une assemblée est un art des plus délicats, et même armé de savantes techniques et de la meilleure volonté du monde, il faut toujours s'attendre à un certain montant de critique, tout organisateur en sait quelque chose.

Pour résumer le tout et obtenir un dénouement heureux, il faut s'assurer les services d'un président actif entouré d'un conseil et de membres collaborateurs et productifs, constamment stimulés par la régularité et la continuité des assemblées.

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Top Priority for Nursing Education

At its December meeting, the Committee on Nursing Education proposed recommendations which are being presented to the Executive Committee at this month's meeting. These include:

1. Further study by members in each province of the Pilot Project for Evaluation of Schools of Nursing.
2. Fact-finding survey of personnel providing instruction in schools of nursing;
3. Proposed guide for curriculum development.

1. It is hoped that through the type of study mentioned above, nurses everywhere will become more familiar with the Pilot Project and all will assist in expressing their beliefs about what is considered a desirable school of nursing. Out of this study should come valuable suggestions for the development of Canadian criteria for the evaluation of our educational programs. Materials from National Office will form the basis for the initiation of such study by the general membership.

2. The survey of teaching personnel in schools of nursing will provide information as to (a) the numbers of instructors to the total student body, (b) the preparation of each as related to her present teaching function. The qualifications of those involved in clinical teaching, whether considered on the teaching staff or not, will also be surveyed. The proposal suggests the survey be conducted in one specific month in 1959. Purpose of this endeavor is to learn how well Canadian nursing is fulfilling the CNA educational policy.* Suggestions for meeting the needs, which may be found to exist, have also been outlined.

3. Since all provinces report interest and activity in the realm of curriculum development, it was agreed that the time is ripe for the preparation of a CNA guide for this purpose. This, it is felt, would give further expression to the CNA statement on policies regarding nursing service and nursing education, and would be welcome guidance to provincial nursing education committees.

These proposals will be considered and voted upon by the CNA Executive Committee in session, February 12 — 14, 1959.

Interpreters of the Pilot Project

In line with the thoughts of the Committee on Nursing Education that all CNA members should know about the project and its aims, it is fitting to suggest that the regional visitors be called upon as interpreters.

The eleven visitors appointed from various regions to assist the Director in evaluating the 25 selected schools have now all been involved in at least one survey. Since last September, 19 of the schools have been surveyed. Each evaluator brought to this experience a rich background of knowledge, and each expressed understanding of survey procedures and the Pilot Project.

All are well qualified to interpret the Pilot Project in their region. It is our hope that local chapters and other interested groups will call upon them to address meetings, so that a greater understanding of the aims of the Project may be accomplished.

The regional visitors are:

Sister Françoise de Chantal, Sudbury,

*Policies Regarding Nursing Service and Nursing Education — Policy #4.

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Board of Review Pilot Project

The November issue, in this column, carried information concerning the meeting of the Board of Review, October 22-24. The names of the Board Members had not been released at that time. It is our pleasure to advise you that the board, selected by the Special Committee on the Pilot Project and approved by the Executive Committee, is composed of the following members:

Mrs. Blanche Duncanson — Toronto

Miss Elsbeth Geiger — Director of Nursing, Phillips Training School, Queen Elizabeth Hospital, Montreal.

Sister Rheault — Hôpital St. Jean, St. Jean, P.Q.

Miss Mary Richmond — Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

Miss Dorothy Riddell — Senior Inspector, Schools of Nursing, Nursing Branch, Ontario Department of Health, Toronto.

Miss Glenna Rowsell — Director of Nursing Education, St. John's General Hospital, St. John's, Nfld.

Sister Mary Thille — Director of Nursing, St. Boniface Hospital, St. Boniface, Manitoba.

Miss Jean Wilson — University of Toronto School of Nursing, Toronto, Ontario.

Representing the Canadian Medical Association:

Dr. A. F. W. Peart — Assistant Secretary.

All members were present at the first meeting in October, with the exception of Sister Rheault. Sister Denise Lefebvre attended in her capacity as senior bilingual evaluator.

Mary Richmond was elected chairman of the Board for the duration of the Pilot Project and the director, Helen Mussallem, secretary.

(* To evaluate French-language schools of nursing.)

The next meeting of the Board of Review has been scheduled for May 25 to May 30, 1959.

Nursing at Springhill

The following information on the part nurses played during the Springhill Disaster was provided upon our request, by **Mrs. Florence Marney**, Secretary, Cumberland Co. Branch, R.N.A.N.S. We present it here:

At approximately 8:10 P.M. on October 23, 1958, Springhill a little town of 7,000 people in Nova Scotia's Cumberland County, suffered its third disaster in two years. An underground upheaval, a bump, occurred in number two coal mines.

Once again military, medical, nursing personnel and people from all walks of life were pressed into service in the town. The hospital's regular staff, on duty 3:00 — 11:00 P.M. was re-enforced by the nurses of the town. Nurses also were on duty in the Armories which was set up as an emergency hospital. During Thursday evening Civil Defence officials moved in and nursing service then came under that group. On Friday six nurses from the neighboring town of Amherst, N.S., sixteen miles away, were brought in on the 7:00 — 3:00 shift and help was also given by three nurses from Grace Hospital, Halifax.

After Friday afternoon, the number of Springhill nurses available was sufficient to carry on the nursing service alone. It was stated at one time by an official that there would be a nurse for every patient. This was carried out whenever necessary and whenever possible.

Nurses also were called upon at one time to assist at the McColl Dressing station, located near the mine entrance, when the nurse on duty at the First aid Station could not handle the work alone.

There was also a psychiatric unit in operation in the town and nurses were on duty at all hours, some from the Nova Scotia Hospital, Halifax, and some local nurses. This service was available to any who felt the need of it and especially to members of the families who had loved ones unaccounted for in the mine and to men who had been already rescued.

The nurses on duty, when not busy with nursing procedures were well oc-

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cupied easing tensed minds by listening to the accounts the men had to tell of the "bump" and the horror it produced for the individual patients.

Miss **Phyllis Lyttle**, Superintendent of Nursing, Department of Health, Province of Nova Scotia and representative of the Provincial Civil Defence Committee, was in charge of organizing the nursing service generally and was on the scene for several days. At All Saints Hospital, Miss **R. Hargraves**, Superintendent of nurses, was in charge of the nursing service and this position at the Armories was capably filled by **Mrs. G. Jones**, one of the local nurses. Offers of assistance were received from nurses from all over the Maritime provinces. It was very heartening for those in charge to know that a wealth of nursing service was available just for the calling, if and when it was needed.

Le Nursing à travers le pays

Prédominance de l'Education en Nursing

Lors de la réunion du Comité de l'Education en Nursing tenue en décembre dernier, les recommandations suivantes ont été faites et seront présentées au Comité Exécutif au cours de ce mois:

1. Que dans chaque province une étude soit faite des objectifs ainsi que des moyens et méthodes employés dans l'exécution du Projet-essai.
2. Qu'un relevé soit fait concernant le personnel enseignant dans les écoles d'infirmières.
3. Qu'un projet de guide soit rédigé pour l'élaboration d'un programme d'études.

Nous espérons que par des études de ce genre toutes les infirmières se familiariseront avec le projet-essai d'évaluation des écoles d'infirmières et qu'elles exprimeront leurs idées sur ce qui, dans leur opinion, peut être considéré comme une bonne école d'infirmières. Cette étude devrait nous fournir de bonnes suggestions qui nous serviront dans l'établissement de critères pour l'évaluation de nos programmes d'enseignement. Le Secrétariat national fournira la matière devant servir de base à cette étude à laquelle devraient participer tous nos membres.

Le relevé concernant le personnel enseignant dans les écoles d'infirmières nous renseignera sur: (a) Le nombre des institutrices par rapport au nombre total d'étudiantes; (b) la préparation de chacune, considérant les matières qu'elle doit enseigner. La préparation des infirmières chargées de l'enseignement clinique, qu'elles fassent ou non partie du personnel enseignant, sera également connue. Il a été suggéré que l'enquête se fasse en 1959, durant un mois déterminé. Le but de cette enquête est de savoir si les infirmières canadiennes suivent la ligne de conduite recommandée par l'A.I.C., en matière d'éducation.* Des suggestions pouvant permettre de répondre aux besoins éventuels ont été exposées.

Comme toutes les provinces se montrent intéressées au développement et au perfectionnement du programme d'enseignement, il semble que le temps soit venu pour l'A.I.C. de préparer un guide à cette fin. Nous croyons que ce serait là une autre occasion d'exprimer la politique de l'A.I.C. concernant l'éducation et le service d'infirmières et que cela serait bien accueilli par les comités provinciaux d'éducation. Ces propositions seront présentées au Comité Exécutif de l'A.I.C. pour étude et approuvées par vote, s'il y a lieu, lors de la réunion du 12 février 1959.

Bureau de Revision du Projet d'Evaluation des Ecoles d'Infirmières

Dans le numéro de novembre, il était question, sous cette rubrique, de la réunion des membres du Bureau de Revision, tenue de 22 au 24 octobre. Le nom des membres n'avait pas été publié alors. Il nous fait plaisir de vous informer que les membres suggérés par le comité spécial du Projet d'Evaluation furent acceptés par le Comité Exécutif et voici leurs noms:

Mme Blanche Duncanson — Toronto.
Mlle Elsbeth Geiger — Directrice du Nursing, Ecole d'Infirmières, Queen Eli-

*Lignes de conduite concernant le Service du Nursing et l'Education en Nursing.

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zabeth Hospital, Montréal.

Soeur Rheault — Hôpital St-Jean, St-Jean, P.Q.

Mlle Mary Richmond — Directrice du Nursing, Royal Jubilee Hospital, Victoria, C.B.

Mlle Dorothy Riddell — Visiteuse, Ecoles d'Infirmières, Ministère de la Santé de la Province d'Ontario, Toronto.

Mlle Glenna Rowsell — Directrice de l'Education en Nursing, St. John's General Hospital, St-Jean, Terreneuve.

Soeur Mary Thille — Directrice du Nursing, Hôpital St-Boniface, St-Boniface, Manitoba.

Mlle Jean Wilson — Ecole d'Infirmières de l'Université de Toronto, Toronto, Ont.

Représentant l'Association Médicale Canadienne: Le docteur A. F. W. Peart — secrétaire-adjoint.

Tous ces membres étaient présents lors de la première réunion tenue en octobre, sauf Soeur Rheault qui fut remplacée par Soeur Denise Lefebvre à titre d'évaluatrice conjointe bilingue.

Mlle Mary Richmond fut élue présidente du Bureau pour la durée du Projet et Mlle H. Mussallem, directrice du projet, en sera la secrétaire.

La prochaine réunion du Bureau de Revision aura lieu du 25 au 30 mai 1959.

Comment faire connaître le Projet?

Le Comité de l'Education en Nursing est d'avis que tous les membres de l'A.I.C. devraient être mis au courant du projet d'évaluation des écoles d'infirmières actuellement en cours, ainsi que du but de cette entreprise. L'on suggère que les visiteuses régionales en soient les interprètes.

Les onze visiteuses régionales nommées pour assister la directrice à l'évaluation des 25 écoles choisies à cette fin, ont toutes participé à l'inspection d'au moins une école. Depuis le mois de septembre 1958, 19 écoles ont ainsi été visitées. Chaque évaluatrice a apporté à l'exécution du projet des connaissances approfondies et a parfaitement compris le sens de ce travail. Chacune d'elles est donc en mesure de faire connaître, dans sa région respective, le projet d'évaluation et d'en expliquer l'exécution et les buts. Nous comptons que les Associations de Districts et autres groupes intéressés inviteront les visiteuses régionales à adresser la parole lors de leurs réunions et collaboreront ainsi à la réalisation de l'objectif du projet.

Les visiteuses régionales sont:

Soeur Françoise de Chantal, Sudbury, Mlle Jeanie S. Clark, Edmonton, Mme Blanche Duncanson, Toronto, Soeur M. Felicitas, Montréal, Mlle Doris Grieve, Fredericton, N.B., Soeur Mary Kathleen, Toronto, Soeur Léontine Mongrain, Régina, Soeur Florence Keegan, Montréal, Mlle Sheila Nixon, Winnipeg, Mlle Mary Richmond, Victoria, Mlle Margaret Street, Calgary.

Les Infirmières à Springhill

Les informations suivantes nous furent données, à notre demande, par Mme F. Marney, secrétaire pour le Comité de Cumberland, de l'Association des Infirmières de la Nouvelle-Ecosse.

Le 23 octobre 1958, Springhill, petite ville de 7,000 âmes, de la Nouvelle-Ecosse, était le siège d'un désastre. Un soulèvement souterrain, un choc violent se produisit dans la mine de charbon No. 2.

Une fois de plus l'on fit appel à l'armée, aux médecins et aux infirmières, de même qu'aux personnes de toutes conditions pouvant venir en aide à la ville affligée. Le personnel régulier des hôpitaux en service de 3 à 11 heures fut aidé par des infirmières de la ville. D'autres infirmières furent assignées à l'arsenal militaire transformé en hôpital d'urgence. Le lendemain, le 24 octobre, la défense civile prit charge des opérations et la direction du service d'infirmières. Le vendredi, six infirmières d'Amherst, ville située à 16 milles de là, vinrent prêter main forte à l'équipe de 7 à 3 heures. Trois infirmières du Grace Hospital, Halifax offrirent aussi leurs services.

A compter du vendredi après-midi, les infirmières de Springhill purent suffire à la tâche. Il fut déclaré à un certain moment, par une autorité, qu'il y aurait une infirmière en service auprès de chaque blessé. Il en fut ainsi lorsque la chose s'avéra nécessaire et fut possible.

Des infirmières furent aussi demandées pour venir aider l'infirmière chargée de la Clinique d'urgence de la mine qui ne pouvait suffire à la tâche.

Une clinique psychiatrique fut ouverte dans la ville, fonctionnant jour et nuit, et où il y avait aussi des infirmières dont quelques-unes de l'Hôpital Nova-Scotia d'Halifax. Les services de cette clinique étaient offerts à tous ceux qui avaient besoin de cette aide, particulièrement aux familles éprouvées dont un de leurs membres était encore au fond de la mine ou venait d'en être ramené.

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*Niedelman, M. L. and Bleier, A.; Jour. Ped., 37:5, 762, Nov. 1950
Fischer, C. C. and Lipschutz, A.; Am. Jour. Dis. Child, 89:5, 596, May 1955
Benson, R. A., et al: Arch. Ped., 73:250 - 8, July 1956

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n'étaient pas occupées à donner des soins physiques, essayaient de diminuer la tension nerveuse en écoutant ce que les escapés racontaient de cette terrible expérience, choc, secousse et horreur terrifiante par laquelle ils avaient passé.

Mlle Phyllis Lyttle, directrice du nursing au Ministère de la Santé de la Nouvelle-Ecosse et représentante du comité provincial de la défense civile, était chargée de l'organisation générale du service du nursing et demeura sur les lieux pendant plusieurs jours.

A l'Hôpital All Saints, Mlle R. Hargraves, directrice des infirmières, fut chargée du service du nursing et cette même fonction, au manège militaire, était remplie avec compétence par Mme G. Jones.

Toutes les infirmières des provinces maritimes furent unanimes à offrir leurs services. La pensée que l'on n'avait, au besoin qu'à appeler au secours fut très réconfortante.

Sawdust Beds

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OUR TWO-STORY QUONSET HUT is now full of patients and our other wards are filled as usual. One of our patients, who was brought in off the street, was an 18-year-old boy weighing 50 lbs. He looked like some of my skinny little "old men" babies. He is now a different boy weighing 75 lbs. We just can't fill him up.

We have a new invention! "Sawdust bed," for treatment and prevention of bedsores in paralyzed or aged patients. One man, paralyzed from the waist down, in spite of a home-made Stryker frame and every nursing care that is possible, had his back break out into a huge bedsore 4" wide and 2" deep. His heels also were affected. Even the pillow used to support his feet caused pressure sores. He was ill-nourished and swollen from malnutrition. We had to do something about it.

We had heard about sawdust beds and recalled reading about them in our nursing magazines, so they were worth a try. Then came the problem of how to make one. A recovery room bed, also a home-made invention consisting of a frame to hold a stretcher, was utilized with a sheet thrown over it to form a pocket for the sawdust. Even to find the sawdust was a problem but we did find it, spread it out in the sun and sifted it. Then with a little prayer we laid our patient *directly on the sawdust*.

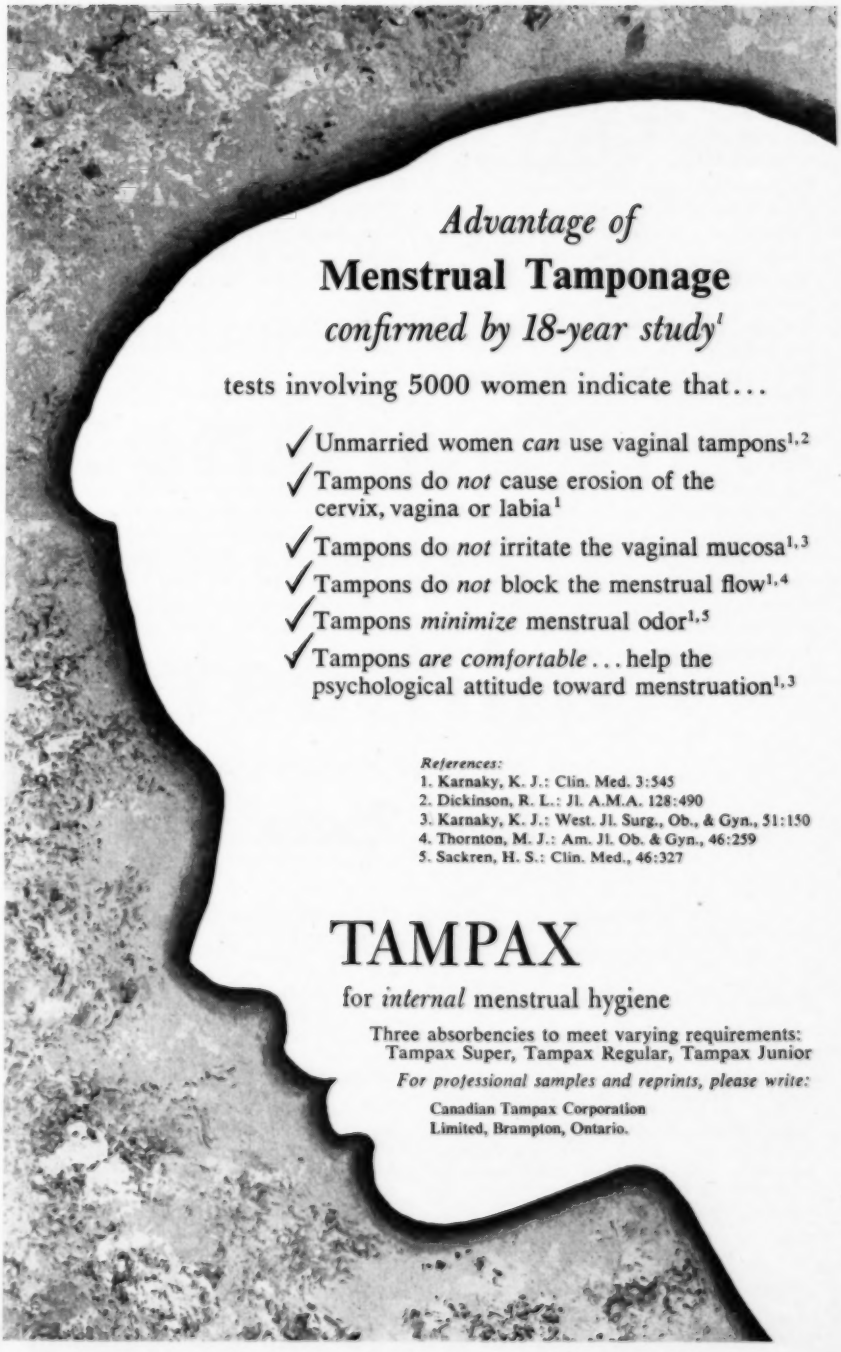
To our astonishment, not many days later, the dirty wound showed signs of healing. Even the skin on his legs looked clearer. A high protein diet helped his general condition. In a few weeks this huge hole was half the size. We can hardly believe it. Now our patient is up in a wheel-chair. We are hoping that somehow we will be able to buy him a wheel-chair for his own use and then he will be able to return home and start a new life.

Sawdust beds are really something. They keep the patient always dry, as wood is highly absorbent; pine wood has a resin or healing oil in it; the sawdust provides enough friction to promote healing and certainly makes nursing care easier. Just wash out the wound several times a day with soap and water, remove damp or lumpy sawdust and replace completely every ten days or as needed. We now have four patients on sawdust beds and certainly recommend them.

Miss Bourns is at Severance Hospital, Seoul, Korea. Her mailing address is c/o Canadian Mission, 190-10, 2 Ka Choong Chung Ro, Sudaimoon Ku, Seoul, Korea.

The British Royal College of Nursing, after working for many years for a shorter working week for nursing staffs in hospitals, welcomed the approval given by the Ministry of Health to the Whitley Council recommendation of a 44-hour work week.

The introduction of these new hours of work will call for considerable planning to avoid detriment to nursing care of patients or sacrificing the teaching of student nurses.



Advantage of

Menstrual Tamponage

confirmed by 18-year study[1]

tests involving 5000 women indicate that...

✓Unmarried women *can* use vaginal tampons[1,2]

✓Tampons do *not* cause erosion of the cervix, vagina or labia[1]

✓Tampons do *not* irritate the vaginal mucosa[1,3]

✓Tampons do *not* block the menstrual flow[1,4]

✓Tampons *minimize* menstrual odor[1,5]

✓Tampons *are comfortable*... help the psychological attitude toward menstruation[1,3]

References:
1. Karnaky, K. J.: Clin. Med. 3:545
2. Dickinson, R. L.: Jl. A.M.A. 128:490
3. Karnaky, K. J.: West. Jl. Surg., Ob., & Gyn., 51:150
4. Thornton, M. J.: Am. Jl. Ob. & Gyn., 46:259
5. Sackren, H. S.: Clin. Med., 46:327

TAMPAX

for *internal* menstrual hygiene

Three absorbencies to meet varying requirements:
Tampax Super, Tampax Regular, Tampax Junior

For professional samples and reprints, please write:

Canadian Tampax Corporation
Limited, Brampton, Ontario.

The Registrar

Ann F. Gavin

Do we ever think, as the days go by,
Of one who is striving to keep
Hundreds of souls contented,
Or the reward she is sure to reap?
The Registrar's duties are arduous.
When she picks up a telephone,
Calling a nurse to night duty,
All she hears is this monotone:
"Seven to three is the duty I take.
I never work nights, you know.
I've given a good many years to this job
And feel able to choose what I do."
Ting-a-ling, ting-a-ling, another call goes.
"Will you take a case for tonight?"
"Oh dear, no! If I'm absent at noon
My husband will not eat a bite.
Three to eleven are the hours I take.
If I change those duties you see
My husband would leave and what would I do
Without home or husband? Poor me!"
Over and over, day after day,
Those self-satisfied savers of lives
Refuse to respond to emergency calls
Regardless of who else survives.
The Registrar, then, so weary of soul,
Calls on nurses who never refuse
Who night after night, go weary to work,
Tho' other hours gladly would choose.
For they are type who put work before play
The patient comes first, they believe,
While the three to eleven, or seven to three,
If they get what they want, do not grieve.
Those much pampered nurses, day after day,
Report to their duties to work.
No "Golden Rule" ever at night spoils their dreams;
As their Nightingale pledges they shirk.
Does it ever, I ask, dawn on them as a sport
To give the night nurses a break,
Or help make the Registrar's duty a job,
With a motto like — well — "Put and take?"
Let's give a thought to that friend of the nurse
Who sits by her desk, day by day,
Trying to keep the machinery at work
With naught but her salary for pay.
A kind word or thought would better her cause,
Good team work would help pave the way
To lighten a task which must sometimes grow stale —
Calling nurses to work night and day.

News Notes

ALBERTA

District 2

Ponoka

A bursary is to be presented by the chapter to a local girl entering nursing in one of the province's hospitals. A total of $125 will be given over the three years in sums of $25, $50 and $50. The bursary will be available to applicants of schools of nursing for September. Mmes Oness, Crowhurst, Kinnear, Clapp and Miss Kemp form the committee entrusted with setting up the award.

District 4

Medicine Hat

Chapter members voted to have a total of nine meetings per year omitting the months of July, August and December. The January meeting was in charge of Miss Helen Clemis and was devoted to civil defence. Mrs. Batter reported on the official opening of the new A.A.R.N. building at a recent meeting.

District 7

Vegreville

Chapter members held a Christmas party again in 1958 for children at Mundare orphanage. The program included a children's movie at the local theatre with lunch served at the nurses' residence afterwards. Each child received a gift, a bag of candy and fruit and a small toy. The Lions' Club provided some financial assistance to make the party possible.

Vermilion

The executive for the coming year of the

Baby's Own Tablets

satisfactorily relieved

every one of 40 babies* with

constipation

and 34 out of 35 babies* with

teething

gastrointestinal upset and malaise

with complete easing of straining at stool, gas distress, disturbed sleep, restlessness, crankiness and anorexia.

REMARKABLY SAFE — "Throughout the study . . . in no instance was there any untoward reaction" whatsoever.

BABY'S OWN TABLETS provide Phenolphthalein 3/16 grain, mildly buffered with Precipitated Calcium Carbonate ½ grain, and Powdered Sugar q.s. Pleasant, convenient.

*2 months to 24 months of age.

For a sample supply and literature citing references 1-15 write . . .

Typical Case History

CASE #50. Baby R.S., age 12 months, weight 20 lb. 10 oz., had gastrointestinal discomfort and malaise associated with teething. Baby had no teeth as yet, but gums were tender, puffy and swollen. Baby was cranky, irritable, restless and couldn't sleep. Drooling was excessive; appetite poor.

BABY'S OWN TABLETS were given, one each night at bedtime.

Baby had satisfactory relief of symptoms. Appetite improved. First days, then nights, became more comfortable. Baby now has six teeth.

G. T. FULFORD CO., LIMITED, Brockville, Ontario

local chapter will be: A. Keith, hon. pres.; Mrs. Z. V. Barr, pres.; Mrs. M. McLoughlen, vice-pres.; Mrs. E. Corley, treas.; Mrs. D. Watt, press; Mmes D. Coulter, E. Waldenberger and Miss J. McPhee, visiting committee. The annual Christmas party was held with the local doctors and their wives, and husbands of the nurses as guests.

Wainwright

The new executive of the Chapter has been elected. The members are: Mrs. E. Mitchell, pres.; Mrs. P. Akyroyd, vice-pres.; Miss J. Thomas, sec.-treas. The local high school girls were invited to attend the opening of the nurses' residence. Miss Doris Sundberg attended a civil defence course in Edmonton and brought back a very interesting report of the program presented. She also arranged to have two films, "Disaster on Main Street," and "Atomic Medical Cases in World War II" shown.

BRITISH COLUMBIA

Penticton

Chapter officers have been elected for 1959. They are: Mrs. L. W. Pigeau, pres.; F. Trout, Mrs. V. Crittenden, vice-pres.; Mrs. I. Cross, treas.; Mrs. W. Peters, rec. sec.; Mrs. M. Smith, corr. sec.; Mrs. D. W. Keir, membership; G. Gow, Mrs. A. Gayfer, "Inklings"; M. Banford, program convener; Mrs. F. Colclough, publicity; Mmes D. M. Deacon, F. Coutts, social committee; Mrs. K. Lucky, sick and visiting convener. The annual dance sponsored by the association, "White Caps," was held at the end of January in the Legion auditorium.

Vancouver

St. Paul's Hospital

The executive of the alumnae association entertained the preclinical students at a doughnut and coke party recently. Different members addressed the students briefly concerning the association and its work. The party was so successful that a decision has been made to make it an annual affair for each new class.

There were 160 members at the Homecoming this year. It was a very pleasant event with members of the classes of '25 and '26 present as honored guests. Joanne (Slade) Cunningham '57 is working at St. Joseph's Hospital, Victoria and Irene Field '53 is doing public health nursing with a child guidance clinic. Irene (Wiest) Witt '46 is studying teaching and supervision at U.B.C. Marion Boyd who completed her studies in public health at McGill last year is presently working at Nelson. Shirley Mermet '56 is on the staff of the Kaiser Foundation, San Francisco. Edith Fraser '49 is doing public health nursing in the city. The December meeting of the association was planned to coincide with the R.N.A.B.C. Christmas party which was held at the hospital this year. Everyone reported a marvellous time.

MANITOBA

District 2

Brandon

General Hospital

Mr. H. L. Crawford, associate editor of *The Brandon Sun*, was the guest speaker at a recent meeting of the alumnae association. He described the moving scenes that marked the closing of the British Empire Games at Cardiff, Wales and then described the tour that took him through England, Scotland and four countries on the continent. Colored slides brought a glimpse of the World's Fair at Brussels to his listeners and took them in imagination on a trip down the Rhine and through Switzerland. Mr. Crawford had met well-known Brandonites now living abroad and had included pictures of them as well to show to their Canadian friends.

It was announced that the nursing service and nursing education committees of the MARN would hold a refresher course in the city in March. The project committee is hoping to install a new refrigerator in the nurses' residence for the use of the students.

NEW BRUNSWICK

Moncton

The Christmas meeting of the chapter was held at Hotel Dieu L'Assomption with the president, Miss Hollenbeck in charge of the meeting. A home nursing class is to be conducted in the hospital during this year. Gifts were forwarded to the Provincial Hospital in Saint John. The student nurses of the hospital provided a program of most enjoyable entertainment for this meeting.

Moncton Hospital

Nurses' Aid

The film on "The Treatment of Erythroblastosis Fetalis by Replacement Transfusion" was shown to members at a recent meeting. It proved to be very interesting and instructive. A Christmas party took the place of the regular meeting in December although routine business was transacted. Gifts for patients in the provincial mental hospitals were placed under the Christmas tree at a local store. A gift was presented to Mrs. R. Sowerby who is moving away from the city. The members sang carols, exchanged gifts and enjoyed a very pleasant social time.

Saint John

Miss Edna Shaw shared her experiences as a tourist in Europe as well as her very interesting collection of colored slides at a recent chapter meeting. Miss Shaw spent several years in Germany teaching the children of Canadian Air Force personnel. A successful bridge party helped to swell association funds.

ONTARIO

CHATHAM

Public General Hospital

Mrs. A. (Jennings) Longeway was the guest speaker at the annual alumnae banquet. She gave a most interesting account of the International Congress of Nurses held in Rome. L. Baird told of her trip to Europe at the December meeting. In place of the usual exchange of gifts, members contributed money to be sent to B. Pardo, a missionary in Hong Kong, to use in her work with the children there. A bakeless bake sale netted a substantial amount of money for the Priscilla Campbell Scholarship Fund.

LONDON

Ontario Hospital

The alumnae association recently elected its new slate of officers. Those members holding office are: D. Kerr, hon. pres.; Mrs. V. Hey, pres.; Mmes M. Millen, C. Forrestall, Miss N. McDowell, vice-pres.; Mrs. M. Wright, sec.; Mrs. Chamber, asst. sec.; Mrs. P. Soutar, treas.; Mrs. E. Grosvenor, flower fund; Miss Padgham, Mmes. Hilgert, Bruner, Fraser, program committee; Mmes Griffen, Garner, Guldiken, refreshments.

WINDSOR

Grace Hospital

A farewell tea was held in honor of senior Major Grace Keeling before she left for her new appointment in Calgary. The student Council held a very successful fashion show late last fall. Proceeds were for the students' recreational activities. M. Robson '44 presently home on furlough from her duties as a missionary in India was the guest speaker at the January meeting.

Hotel Dieu Hospital

The annual bazaar sponsored by the alumnae association was particularly successful this year. There was a net profit of almost $500. One of the special highlights of the bazaar was the presentation of a gift to Sr. Marie de la Ferre (accepted by Sr. Superior in Sr. Marie's absence) on the occasion of her golden jubilee in the religious order. This anniversary has been marked by a number of events in the hospital. The December meeting was a Christmas party with each member bringing a box lunch that was eventually auctioned, and a small Christmas gift.

C. Meloche '51 is now an intravenous therapy nurse at Highland Park General Hospital. M. (Harper) Paul '53 is working in San Francisco.

DISTRICT 4

HAMILTON

The annual dinner meeting of the district was held late last fall with an attendance of 400 members. The guest speaker was Mrs. A. Sengkusch, dean of the School of Nursing, University of Buffalo. Her theme was "Trends and Outlook in Nursing for the Future." She stressed the responsibility that the professional group has for initiating changes, evaluating results and determining the value of such changes to nursing. The officers elected were: Mrs. Geneva Lewis, pres.; Edith Bingeman, Evelyn Dougler, vice-pres.; Mrs. Pat Grant, secretary; Mrs. Esther Cunningham, treas.

In
MATINÉE
you'll find
the finest...

A cigarette of elegance...
A filter of particular purity

DISTRICT 6

BELLEVILLE

General Hospital

The tea and bazaar held last fall was a tremendous success, the total proceeds being $548. Miss M. L. Peart planned and directed a pageant of nursing that received many favorable comments. The annual Christmas party was in the form of a potluck supper with the members putting 50 cents each into a general fund for use by the Salvation Army. The hospital chapel was recently completed and an opening service held. It is located in the basement of the building and is attractively decorated in blond and green with broadloom carpeting and comfortably upholstered chairs in harmonizing tones. A Hammond organ has also been installed.

Congratulations are extended to the graduating class of 1958 whose members passed all registration examinations successfully. The school of nursing is also proud to report that

In feminine hygiene and therapy

Massengill Powder

An astringent, soothing vaginal douche, therapeutically valuable in the management of infection and as a routine cleansing agent. Its refreshing odor appeals to the most fastidious patient. Available in 3 and 6 oz. jars. Samples on request.

THE S. E. MASSENGILL COMPANY
FORT ERIE, ONTARIO

facilities for experience in pediatric nursing have been expanded to an extent that students no longer need to affiliate elsewhere.

SASKATCHEWAN

SWIFT CURRENT

Chapter members gathered in the main lounge of the new nurses' residence in December for their first meeting in the room that they have furnished for the hospital. Mrs. F. Verret presided. A drawing is to be held in February as a fund raising project since this has proved so successful in former years. Mrs. J. Craig was appointed corresponding secretary — permission having been received by the chapter to add this office to their executive. Mrs. C. D. Lee reported on the recent workshop in mental health. The film "Girls in White" was shown with four collegiate students, prospective nurses, as particularly interested observers. The girls had an excellent opportunity to find out more about the profession as they talked to their nurse hostesses. Chapter members and their guests were taken on a tour of the residence at the close of the meeting.

Union Hospital

In November, 1958, members of the Board proudly welcomed citizens of the district to the opening of the new nurses' residence and wing of the hospital. The completion of these building projects means that the hospital now has accommodation for 177 patients and 78 nurses. Mr. I. Hansen, chairman of the Board, greeted the guests at the official ceremony while L. E. Plewis, deputy mayor, J. McIntosh, M.L.A. and Everett I. Wood, M.L.A. gave brief messages of congratulation and praise. Reverend J. K. Johnson of the local Ministerial Association dedicated the building and the ribbon cutting ceremony was performed by the Honorable J. Walter Erb, Minister of Public Health for Saskatchewan.

SASKATOON

St. Paul's Hospital

Candle-bearing student nurses carolled their way through each ward in the hospital to the delight of their patients, as part of the hospital's Christmas festivities. Twenty senior students received their coveted black bands in December and were guests of the graduate staff at their inservice educational program on the neurosurgical care of a patient. The meeting was followed by a social hour of music and refreshments.

Nurses and doctors enjoyed a Christmas concert presented by the student nurses and featuring carol singing by the Junior and Senior Glee Clubs under the direction of Miss D. Skinner and Mr. U. Doulevy respectively; a piano duet, vocal solo and Ukrainian dancing by Class IA; and the presentation of "The Waif" — a Christmas story.

THAT ALL UNIFORMS CLOTHING AND OTHER BELONGINGS ARE MARKED WITH

CASH'S NAMES

Permanent, easy identification. Easily sewn on or attached with No-So Cement. From dealers or CASH'S Belleville 5, Ont.

CASH'S: 3 Doz. $1.80; 9 Doz. $3.00; NO-SO NAMES: 6 Doz. $2.40; 12 Doz. $3.50; 35¢ per tube

Employment Opportunities

ADVERTISING RATES — *$5.00 for 3 lines or less; $1.00 for each additional line.*
U.S.A. & Foreign — *$7.50 for 3 lines or less; $1.50 for each additional line.*

Closing date for copy and cancellations: 10th of the month preceding the month of publication. All letters should be addressed to: The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Quebec.

Director of Nursing for new 33-bed General Hospital with well equipped surgery wing, in new mining town, about 250-mi. east of Port Arthur & northwest of White River, Ontario. Starting salary commensurate with experience & qualifications. Apply, stating qualifications, experience, age, marital status, etc. to Mr. W. Harrison, Room 1715, 44 King Street West, Toronto, Phone EMpire 4-1194, or to the Administrator, Manitouwadge General Hospital, Manitouwadge, Ontario, Phone TAylor 6-3251.

Director of Nursing for 180-bed hospital with a school of nursing. Applicant with University Degree &/or postgraduate course preferred. Salary commensurate with experience & qualifications, position available May 1959. Apply: Secretary, Board of Directors, Victoria Union Hospital, Prince Albert, Sask.

Assistant Director of Nursing Education & Surgical Clinical Instructor for 85-student School of Nursing, 200-bed hospital, good personnel policies. Apply Director of Nursing Education, St. Michael's Hospital, Lethbridge, Alberta.

Director of Nursing Education for 500-bed General Hospital with school of nursing. Applicant must have a degree in nursing. Salary commensurate with experience & qualifications. Apply to, Director of Nursing, Royal Jubilee Hospital, Victoria, British Columbia.

Nursing Supervisor for community owned 18-bed General Hospital. Full maintenance $48 per mo., in new modern nurses' residence on hospital grounds. Scenic location, in Rocky Mountains west of Calgary, Alberta on Trans Canada Highway. For full particulars write: C. F. Collins, Secretary, General Hospital, Golden, British Columbia.

Nursing Supervisor for northern hospital. Good salary, good living conditions. Apply: The Matron, Yellowknife District Hospital, Yellowknife, North West Territories.

Operating Room Supervisor, Operating Room General Duty Nurse for 110-bed modern hospital. Excellent personnel policies. Apply: Superintendent, Charlotte County Hospital, St. Stephen, New Brunswick.

Operating Room Supervisor (Immediately) for 86-bed hospital. Good salary, employee benefits & statutory holidays, living accommodation available in residence. Locate in Collingwood & enjoy many winter sports along with excellent skiing in the Blue Mountains. Apply, Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

Registered Nurse Supervisors & Staff Nurses (experienced) for outstanding 400-bed hospital & home for aged. All shifts (3-11 P.M., 11 P.M. - 7 A.M., 7 A.M. - 3 P.M.) Starting salary $375 & $330 per mo. Attractive living quarters available. Good personnel policies. Send complete resume, Attention: Nursing Director, Menorah Home & Hospital for aged, 871 Bushwick Avenue, Brooklyn 21, New York.

Superintendent of Nurses for Community Hospital, situated 7-mi. from Dawson Creek, B.C. Starting salary $300 per mo. with yearly increments of $10 starting after 6-mo. of service. 28 days annual vacation, 40-hr. wk. Matron's suite available in nurses' residence. Monthly maintenance deduction $40. Apply to Administrator, Community Hospital, Pouce Coupe, British Columbia.

Assistant Head Nurses excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Clinical Instructor (Medical Nursing) salary $3,480-$4,440 per annum. 40-hr. week. Apply to, Director of Nursing, City Hospital, Saskatoon, Saskatchewan.

Registered Nurses (3) for Municipal Hospital. Duties to commence January 1, 1959 or as soon as possible thereafter. Address correspondence to, The Matron, Municipal Hospital, Three Hills, Alberta.

Registered Nurses for modern hospital. comfortable home. Starting salary $250 per mo., maintenance $35 per mo. Apply: Superintendent, Lorne Memorial Medical Nursing Unit, Swan Lake, Manitoba.

Registered Nurses; for 50-bed Hospital, Obstetrical & General Duty. Rotating shifts, 40-hr. wk. Apply: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario.

Registered Nurses for General Duty modern 18-bed Private Hospital in Iron Mining town, 180-mi. north of Sault Ste. Marie, Ont. Excellent accommodations & personnel policies. Starting salary $255 minimum to $290 maximum for experience, less $20 per mo. maintenance. Transportation allowance after 3-mo. service. Apply Superintendent, Miss O. Keswick, Lady Dunn Hospital, Jamestown, Ontario.

Registered Nurses for general duty in all departments — including operating room, premature & newborn nursery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurse (1) for September 1959, to take charge of infirmary in a residential school, housing approximately 100 boys between 9 & 14 years. Suite of rooms provided adjacent to infirmary. Would prefer applicant in early middle age. Apply: Headmaster, Ridley College, St. Catharines, Ontario.

Registered Nurses: Positions available in all areas & on all shifts. Ultra modern, new 254-bed General Hospital located in the heart of beautiful sunny Castro Valley, just 30 minutes drive from San Francisco. This is a busy residential community which offers casual California living at its very best. Many excellent schools & colleges within easy commuting distance. Progressive personnel policies include free hospital & surgical insurance, paid sick leave, paid vacations, 7 recognized holidays & other benefits. No split shifts; evening & night duty salary differential, also differential paid for operating room, delivery room & nursery service. Uniforms laundered free. Basic salary for general staff duty, $320 per mo. Salaries for other positions commensurate with assignments. Please write: Personnel Manager, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, Calif.

Registered Nurses: Are you interested in a starting salary of $355.00 per month? We have openings on all services in our new 525-bed Osteopathic Unit scheduled to open about April 1. All R.N.s must speak and write English. For full details, write Betty Hartwig, R.N., Los Angeles County General Hospital, 1200 North State Street, Los Angeles 33, California. We will help you with registration.

Registered Nurses for new 157-bed General Hospital located in fast growing City of Fremont approximately 1-hr. from heart of San Francisco. Good salary, vacation, sick leave & hospitalization plan. Contact Director of Nursing Services, Washington Township Hospital, P.O. Box 656, Niles, California.

Registered Nurses: Spend your winter in the Sunny Southwest — New Mexico, "The land of Enchantment". Vacancies for staff duty in Medicine, Surgery, Obstetrics, Pediatrics, and Operating Room. Salaries $285-$315, days; $10 differential for evenings & nights; $15 differential, operating room. No shift rotation. Excellent job benefits. Board and room in nurses' residence, $43 per month. Free transportation via 1st Class Air travel to Albuquerque and return in exchange for a 1-yr. employment contract. Write or call collect Mrs. Margaret Nelson, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Ave. S.E. Albuquerque, New Mexico. Phone 3-5611.

Registered Nurses & Certified Nursing Assistants (immediately) for 73-bed General Hospital on Lake of the Woods. Favorable salaries & personnel policies. Living conditions available. Apply Superintendent, Kenora General Hospital, Kenora, Ontario.

Registered Nurses & Certified Nursing Assistants for new expanding 88-bed hospital in a pleasant progressive town. **General Duty Registered Nurses** start $220, annual increments to $240, **Certified Nursing Assistants** $150, annual increments to $180. 2-wk. shift rotation, bonus for 4-12 & 12-8 shifts. Accumulated sick leave to 60-dy. Only 1-hr. drive to Toronto, to other cities & resort areas. Local swimming pool, artificial ice arena, bowling, etc. Apply: Director of Nursing, Dufferin Area Hospital, Orangeville, Ontario.

Registered Nurses & Licensed Practical Nurses for new 33-bed General Hospital with well equipped surgery wing, in new mining town, about 250-mi. east of Port Arthur & northwest of White River, Ontario. Starting salary commensurate with experience & qualifications. Apply: stating qualifications, experience, age, marital status, etc. to Mr. W. Harrison, Room 1715, 44 King Street West, Toronto, Phone EMpire 4-1194, or to Administrator, Manitouwadge General Hospital, Manitouwadge, Ontario, Phone TAylor 6-3251.

Registered Nurse & Licensed Practical Nurse for general floor duty. Gross salary $290 per month for R.N., $200 per month for L.P.N. with $25 deducted for full maintenance. 44-hr. week. For further particulars please apply to John Hiscock, Secretary-Treasurer, Medical Nursing Unit, Baldur, Manitoba.

Registered Nurses for General Duty Staff. Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for Operating Room with operating room postgraduate courses and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000 **Salary: $260 per mo.** with semi-annual merit increments, **plus annual bonus plan.** Recognition for experience. Excellent personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Laboratory Technician (Male or Female) will consider recent graduate who has not taken the Registry. Good personnel policies; salary open. Write or phone: Administrator, Sidney A. Sumby Hospital, River Rouge 18, Michigan.

Surgical Registered Nurses, Staff Registered Nurses for 240-bed General Hospital. 40-hr. wk. 15 working days; paid vacation; 7 paid holidays; sick leave. Surgery starting base pay $338 stand by & call back time extra. **Staff R.N.** starting pay $322 monthly; regular pay increases; P.M. & night differential $10. Apply: Yolo General Hospital, P.O. Box 210, Woodland, California.

Registered General Duty Nurses (2) Starting salary $260 gross, personnel policy upon request, living in residence. Apply, Matron, Myrnam Municipal Hospital, Myrnam, Alta.

Registered General Duty Nurses. Salary: $230 per mo. 40-hr. wk. Apply Director of Nursing General Hospital, Cobourg, Ontario.

Registered General Duty Nurses for **118-bed General Hospital** along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $340 for days, $370 for evenings, $360 for nights. 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Registered Nurses for 100-bed General Hospital in town of 6000 on shore of Lake Huron. Good personnel policies, 5-day wk., residence accommodation available. Please apply to Superintendent, Alexandra Marine & General Hospital, Goderich, Ont.

General Duty Registered Nurses & Operating Room Nurse (1) for new 56-bed hospital on Georgian Bay. Attractive residence. Gross salary $225 per mo. for general duty, 44-hr. wk. All statutory holidays, 12-dy. sick leave. 3-wk. vacation after 1-yr. Apply to Director of Nursing, Meaford General Hospital, Meaford, Ontario.

Baker Memorial Sanatorium, Calgary, Alberta, offers to Graduate Nurses a 6-mo. post-graduate course in Tuberculosis. Salary: $3,480 to $4,080 per annum. Openings also available for **General Duty Nurses.** Residence with board, if desired, $30 per mo. Excellent holiday, sick leave & pension benefits. Apply to: Superintendent of Nurses.

General Duty Nurses for small active hospital. Salary $250 for unregistered. $260 registered with yearly increments. Nurses' Home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia.

General Duty Nurses for R. W. Large Memorial Hospital United Church of Canada at Bella Bella 300-mi., north of Vancouver on B.C. Coast. Transportation refunded after 1-yr., Apply to, Matron, R. W. Large Memorial Hospital, Bella Bella, British Columbia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $250-$260. Good personnel policies with sick leave benefits holidays & paid vacations. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses (immediately) for 105-bed General Hospital. Salary $220 per mo. with annual increments of $10 per mo., 40-hr. wk., 21 days vacation after 1-yr. 31 days after 2-yr. Room, board & laundry $35 per mo. Apply: Director of Nursing, St. Andrews Hospital, Midland, Ontario.

McKellar General Hospital, Fort William, Ontario requires **General Duty Staff Nurses** interested in coming to northwestern Ontario. Basic salary, $250 per mo. 40-hr. wk. Good personnel policies. Renovation program now complete. Openings in all departments. For further information apply to the Director of Nursing.

General Duty Nurses for modern 42-bed hospital, starting salary, new graduates $255 with two (2) yr. experience $270 provided Ontario registration is obtained; these rates to be revised October 1st. Ontario registration required for maximum salary. Annual increments, 6% bonus for evening & night shifts. 44-hr. wk. with 8 statutory holidays, annual vacation 21 days first yr. 28-dy. thereafter, monthly sick time allowance. Good living accommodations available. Apply to: Nursing Supervisor, Sioux Lookout General Hospital, Sioux Lookout, Ontario.

General Duty Nurses (English speaking) for 466-bed hospital. Nurses' residence available. Salary: $315, California registered — $285, Canadian registered. $22.50 differential for 3-11 & 11-7 shifts. Apply Cedars of Lebanon Hospital, 4833 Fountain Ave., Los Angeles, Calif.

General Duty Nurses (all shifts) for 140-bed hospital Central California. $310 per mo., plus $10 for 3-11 p.m. & 11 p.m.-7 a.m., yearly increases. 5-day wk. paid holidays, paid sick leave & vacation plan. **Supervisor** 3-11 p.m., $351 to start. **Operating Room Nurse** $325 to start. Living quarters on grounds. Write to Director of Nurses, Madera County Hospital, Madera, California.

General Duty Nurses for 600-bed teaching hospital in central California. Inservice educational program; 40-hr. wk., 11-holidays yearly, retirement & sick leave plan. P.M. & night shift differential. $337 per-mo. to start. Write Personnel Director, 732 East Main St., Stockton, California.

General Duty Nurses (California, between Sacramento & San Francisco) for 84-bed general short term JCAH hospital. Starting salary $325, nurses' home, excellent working conditions. Write, Director of Nurses, Clinic Hospital, Woodland, California.

General Duty Nurses & Operating Room Nurses for 434-bed hospital; 40-hr. wk. Statutory holidays. Salary $250-$312. Credit for past experience & postgraduate training. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

Attention! General Duty & Surgery Nurses for 400-bed County Hospital located 2-hr. drive from San Francisco, ocean beaches, & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., 3-wk. paid vacation, 11 paid holidays, paid sick leave, retirement plan & social security. Accommodations in Nurses' Home, meals at reasonable rates, uniforms laundered without charge. General Duty, $333 mo. start plus shift & service differentials. Surgery $382-$460 mo. comp. time if on call. Must be eligible for Calif. Registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

General Duty Nurses & Certified Nursing Assistants for 86-bed hospital. Living accommodation available. Collingwood is situated on Georgian Bay & is noted as a vacation land in summer with 7-mi. of sand beach, along with great skiing on the Blue Mountains in winter. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Graduate Nurses for an active 76-bed hospital near Calgary & Banff. $250 gross salary, $260 for Alberta registered, good personnel policy. Apply to Matron, Brooks Municipal Hospital, Brooks, Alberta.

General Duty Graduate Nurses (2). Salary $260 per mo. with annual increments of $10 per mo. Room, board & laundry: $40. 28-day vacation after 1-yr. service. All statutory holidays paid. Customary sick leave. Graduate complement, 5. Apply giving full details to Matron, Slocan Community Hospital, New Denver, B.C.

Graduate Nurses for 70-bed General Hospital. Salary $260-$280; 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 yr. Apply: Matron, St. George's Hospital, Alert Bay. British Columbia.

Graduate Nurses for new 140-bed hospital. 1. Charge nurse for Central Supply, to open and organize dept. 2. Head nurse for Pediatric dept. 3. Head nurse for men's Medical and Surgical 24-bed dept. 4. Operating Room nurse (1) 5. General duty nurses. Positions 1 to 4 all to have postgraduate courses or equivalent in experience. Salaries and personnel policies in accordance with R.N.A.B.C. Positions open August to November 1. Apply, Director of Nursing, General Hospital, Chilliwack, British Columbia.

Graduate Nurses: for new 63-bed hospital, 30 miles from Vancouver in the Fraser Valley. For Salary rates & Personnel policies. Apply: Director of Nursing, Maple Ridge Hospital, Haney, British Columbia.

Graduate Nurses for 37-bed hospital, salary $250 per mo. with annual increments — 28-dy. annual vacation, cumulative sick leave — $50 monthly; board, lodging, laundry. New 50-bed hospital to be erected 1959. Apply: Administrator, Terrace & District Hospital, Box 1297, Terrace, British Columbia.

Graduate Nurses for Eastern Townships Hospital. 28 days annual holiday. Complete maintenance. Salary commensurate with experience. Apply, E. Decker, Brome-Missisquoi-Perkins Hospital, Sweetsburg, Quebec.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

General Staff Nurses for 300-bed approved hospital & school of nursing. Salary $250 per mo. plus $10 & $5 for pm & night differential. Annual increment for 3-yr. 8-hr. day; 5-day wk; 3-wk. vacation; pension plan; sick time allowance; 8 statutory holidays; partial payment of health plan. Apply :Director of Nursing, St. Thomas-Elgin General Hospital, St. Thomas, Ontario.

General Staff Nurses for 370-bed approved General Hospital with intern & resident program. $315 per mo. starting salary. $15 per mo. merit increases at 12, 24 & 36 mo. 40-hr. wk. 2-wk. paid vacation, paid sick leave, 7 paid holidays. Pleasant coast city in outstanding recreational area. Apply Director of Personnel, Seaside Memorial Hospital, Long Beach 13, California.

General Staff Nurses for fully accredited private teaching hospital, located on Lake Michigan just north of Chicago. 5-day, 40-hr. wk. Salary range $337.35 to $363.30. Shift bonus: $26 afternoons & $17 nights. Progressive personnel policies. Please indicate type of service preferred. Apply: Director of Nursing, Evanston Hospital, 2650 Ridge Avenue, Evanston, Illinois.

Staff Nurses (3 immediately) for 18-bed Community Hospital in scenic setting in the heart of the Canadian Rockies. Starting salary $250 per mo. Fulll maintenance available in modern nurses' residence. For full particulars write: C. F. Collins, Secretary, General Hospital, Golden, British Columbia.

Staff Nurses for 250-bed General Hospital, located on the Bay of Quinte; approved School of Nursing; planned In-Service education program; desirable personnel policies. For further information, Apply to: Director of Nursing, General Hospital, Belleville, Ontario.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity. Liberal personnel policies. Salary $320-$360. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Staff Nurses: Relocate to Sacramento, Calif. Sutter Community Hospitals, 440-beds, offer $340 per mo. starting salary, $25 per mo. for p.m. & night differential. Tenure salary increase plan, 40-hr. wk., Social Security & liberal employee benefit program. Write to Personnel Office.

Pediatric Nurses for 100-bed Pediatric teaching hospital; air conditioned. Good personnel policies. Base salary-rotation $290 per mo. Evenings or night $304 per mo. Apply: Director of Nursing Service, University of Texas Medical Branch, Galveston, Texas.

Operating Room Nurse for 106-bed hospital. New hospital & nurses' residence to be completed this year. For information regarding duties & salary please write to the Director of Nursing, Prince George & District Hospital, Prince George, British Columbia.

Operating Room Nurse (P.M.) for 147-bed General Hospital located in a beautiful residential surburb along the North Shore of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40 hr. wk. Salary: $365 for days, $395 for evenings. Other employee benefits. Contact the Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Public Health Nurse (qualified) for completely generalized program. Salary range, pension plan & other personnel policy given on request. Applicant must have car. Apply to Dr. Bert Cross, Muskoka District Health Unit, Bracebridge, Ontario.

Public Health Nurse (Qualified) minimum salary $3,200; allowance for experience. $150 annual increments; 5-day week; 4wk. vacation; sick leave credits; Blue Cross, pension plan, car allowance. Financial assistance towards purchase of car. Apply to Mr. A. F. Stewart, Secretary-Treas., Wentworth County Health Unit, Court House, Hamilton, Ontario.

Public Health Nurses: required in a generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group insurance & transportation arrangements. Write: Dr. R. M. King, York County Health Unit, Newmarket, Ontario.

Chief Dietitian for 140-bed hospital. Training school affiliated with Montreal hospitals. Fare paid. For particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

Dietitian for 90-bed accredited Hospital. Help maintain patients contact; salary open, excellent benefits. Write or phone: Administrator, Sidney A. Sumby Hospital, River Rouge 18, Michigan.

Metabolic Ward Nurses Experience or interest in nursing techniques on special care unit involved in giving special diets, special medicines & insuring accurate collections. New state hospital devoted to investigation & treatment of patients with chronic illnesses requiring active hospital care. Affiliated with medical schools for teaching. Salary from $67.25 to $86.75 per wk., based on experience. Liberal sickness & retirement benefits, evening & night differential. Rooms available at $9 per mo. & meals at 30 cents each Apply Director of Nursing, Lemuel Shattuck Hospital, Boston 30, Massachusetts.

Night Supervisor & General Duty Nurses for 65-bed JCAH Hospital. Co-Ed College of 1500 students. Apply Administrator, Berea College Hospital, Inc., Berea, Kentucky.

Registered Nurse (1) immediately for Margaret Cochenour Memorial Hospital (modern 15-bed) located on the lake in Red Lake mining district & tourist area. New nurses' residence beautifully furnished. Salary: $275 basic with increment plan. Maintenance, including uniform laundry, $30 per mo. 44-hr. wk. Holidays. 4-wk. vacation with pay yearly. Transportation expense will be paid after 6-mo. employment. Apply, stating age & references to, I. MacNaughton, Matron, Cochenour, Ontario.

Registered General Duty Nurses (Immediately) for 100-bed Public Hospital in eastern Ontario. 44-hr. wk., 2-wk. sick leave, 3-wk. annual vacation. Apply, Superintendent, Public Hospital, Smiths Falls, Ontario.

Registered & Graduate Nurses for General Duty. Apply, Superintendent of Nurses, Muskoka Hospital, Gravenhurst, Ontario.

Registered Nurse (1), Licensed Practical Nurse (1) as soon as possible for 30-bed hospital. Excellent working conditions. 40-hr. wk., overtime pay, living quarters. Salaries $260 & $195 per mo. respectively with $5.00 increases every 6-mo. Apply stating age & qualifications to, Mrs. R. Maiers, Superintendent, District Hospital, Roblin, Manitoba, or phone 180 collect.

General Duty Nurse for new active 25-bed hospital in Rocky Mountain vacation land, 2-hr. drive from Banff. Many recreational facilities. Policies according to RNABC. Full maintenance in modern residence, $40 per mo. Apply, Matron, Windermere District Hospital, Invermere, British Columbia.

Staff Nurses for 165-bed pediatric teaching hospital. Salary: $315-$348. 40-hr. wk., 6 holidays, 10-day sick leave, vacation. Night or eve. differential, $2.00 per shift. 3-mo. psychiatric training required for Mo. registration. Apply to, St. Louis Children's Hospital, 500 So. Kingshighway, St. Louis 8, Missouri.

General Duty Nurses, O.R. Scrub Nurse (For Summer Relief) in modern well equipped 100-bed General Hospital in a friendly community. Gross Salary $260 per mo. for nurses currently registered in Ontario. 8-hr. rotating shifts, 44-hr. wk. 1 day off 1-wk. & 2 the next; 21 days vacation after 1-yr; 7 legal holidays per yr. Apply: Miss Willamene R. Allan, Reg.N. General Hospital, Port Colborne, Ontario.

PUBLIC HEALTH NURSES GRADE (1)

British Columbia Civil Service

Positions available for qualified Public Health Nurses in various centres in B.C.

Salary: $290 rising to $345 per mo., car provided. An opportunity for interesting & challenging professional service in this beautiful & fast developing province. Competition No.: 58:511.

For information & application forms, write

THE DIRECTOR,
PUBLIC HEALTH NURSING, DEPT. OF HEALTH, VICTORIA, B.C. or
THE CHAIRMAN,
B.C. CIVIL SERVICE COMMISSION, 544 MICHIGAN STREET, VICTORIA, B.C.

Registered Nurse for Private Boy's Camp (July & August). Use of camp facilities, riding, swimming, canoeing etc. Maximum amount of leisure time. Opportunity to assist with camp activities. Salary: $150 per mo. plus comfortable accommodation & meals. Apply Rocky Mountain Boy's Camp, Invermere P.O. British Columbia.

Night Supervisor (8:00 p.m.-8:00 a.m.) 4 nights weekly for small Tuberculosis Hospital. Write stating age, experience, when available to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke Street East, Montreal, Que.

Superintendent of Nurses (March 1/59) for modern 23-bed hospital, 40-hr. wk. salary range $310-$395 per mo., board & room $34.50 per mo. Separate suite in new nurses' residence. Excellent train & bus connections with Prince Albert, Saskatoon & Regina. Apply giving qualifications to J. L. Fawcett, Sec.-Manager, Union Hospital, Rosthern, Saskatchewan.

REGISTERED NURSES — $3,000-$3,540

(According to Qualifications)

SUNNYBROOK HOSPITAL
TORONTO

WESTMINSTER HOSPITAL
LONDON

Employees in both hospitals work a 5-dy. wk.

Application forms available at your nearest Civil Service Commission Offices, or main Post Office, should be forwarded to the CIVIL SERVICE COMMISSION, 25 ST. CLAIR AVENUE EAST, TORONTO 7, as soon as possible.

KEY EXECUTIVE POSITION BEING ESTABLISHED

With the increased professional activities of the Registered Nurses' Association of Ontario a new executive position recently has been created.

ASSISTANT EXECUTIVE SECRETARY

Responsibilities will be in administration and RNAO committee work. Salary range, related to professional qualifications, is $5,250 — $6,560 per annum.

Requirements include organization staff experience or administration experience in nursing service or nursing education. Degree preparation preferred.

Applications should include fullest details of academic and work background, age, when available. ALL will be treated in strict confidence.

Write: EXECUTIVE SECRETARY,
REGISTERED NURSES' ASSOCIATION OF ONTARIO,
33 PRICE STREET, TORONTO, ONTARIO.

EDUCATIONAL DIRECTOR
FOR SCHOOL OF NURSING

50-students, 1-class a year. Good personnel policies. Salary according to qualifications. Present Director of Nursing was former Educational Director of School. Excellent relationships between hospital administrative staff & nursing school. Cornwall "The Hub of the Seaway" is an attractive, progressive city on international border easily accessible to Montreal & Ottawa.

APPLY:

DIRECTOR OF NURSING, GENERAL HOSPITAL, CORNWALL, ONTARIO

GRENFELL LABRADOR MEDICAL MISSION

The Grenfell Mission is now accepting applications for positions in its Hospitals, Nursing Stations and Children's Dormitories in northern Newfoundland and Labrador.

Excellent living conditions and splendid opportunities for varied and valuable experience.

For full information please write:

MISS DOROTHY A. PLANT, SECRETARY, GRENFELL LABRADOR MEDICAL MISSION
48 SPARKS STREET, OTTAWA 4, ONTARIO

APPLICATIONS ARE INVITED BY
THE BROCKVILLE GENERAL HOSPITAL, BROCKVILLE, ONTARIO

for the following positions:

1. Assistant Director, Nursing Education.
2. Operating Room Supervisor.
3. Obstetrical Supervisor.
   Postgraduate training is essential and experience in teaching desirable.
4. General duty nurses for Operating Room also Medical and Surgical Departments.
   Salaries Commensurate with preparation and experience.

For details apply to:

DIRECTOR OF NURSING

GENERAL DUTY NURSES AND CERTIFIED NURSING ASSISTANTS

for modern 50-bed hospital in south western Ontario. Starting salary, **Registered Nurses** $240; **Certified Nursing Assistants** $150 with 3 increments. 5-day wk., 3-wk. annual vacation, 7 statutory holidays, accumulative sick time & $15 shift differential. Hospital pays ½ of hospital medical plan.

APPLY: DIRRECTOR OF NURSES
ALEXANDRA HOSPITAL, INGERSOLL, ONTARIO

GENERAL DUTY NURSES
(Graduates) for U.S.A.

236-bed hospital. 30 miles from New York City. Apt. style residence. Good salary. Free benefits. Pension plan.

Apply:

DIRECTOR OF NURSING,
MEMORIAL HOSPITAL, MORRISTOWN,
NEW JERSEY, U.S.A.

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $255-$305 per mo. Certified Nursing Assistants $190-$210 per mo. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON, TORONTO 15, ONTARIO — CH 4-5551

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo. 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

KINGSTON GENERAL HOSPITAL

KINGSTON, ONTARIO

requires

Director of Nursing Education (1) by July, 1959. Qualifications — Bachelor of Science in Nursing Degree plus 3-5 years experience.

IMMEDIATELY

1. Qualified Clinical Instructresses. Maternity (1) and Surgery (2).
2. General Duty Nurses (12)
3. Certified Nursing Assistants (12).

Salary commensurate with preparation & experience.

Apply: Director of Nursing

SARNIA, ONTARIO

CANADA'S CHEMICAL VALLEY

AND

PORTAL TO OUR BEAUTIFUL BLUEWATER COUNTRY

You will enjoy being a part of this progressive, growing community as an employee of the Sarnia General Hospital.

Positions available in all services for

REGISTERED NURSES

Excellent Personnel Policies include 40-hour week, 3 weeks paid annual vacation, 9 statutory holidays.

Salary range $2,938 to $3,640

Please apply to:

PERSONNEL DIRECTOR
SARNIA GENERAL HOSPITAL,
SARNIA, ONTARIO

PSYCHIATRIC NURSING INSTRUCTRESSES

required by the

SASK. DEPT. OF PUBLIC HEALTH

SALARY: $375 per month for those with postgraduate training; $359 for those without this training.

REQUIREMENTS: R.P.N. and/or Reg. N., preferably both registrations and postgraduate training in nursing teaching and supervision. Consideration will be given to those who have registration in either field of nursing but who do not have the required postgraduate training but are interested in provisional appointments pending formal training for which financial assistance may be provided.

DUTIES: Appointees will serve as instructresses in a three year, 600 hour training program for student psychiatric nurses. They will give lectures, lead seminars and give practical demonstrations designed to co-ordinate classroom theory and work on the wards.

APPLICATIONS: Forms and further information available at Public Service Commission, Legislative Bldg., Regina. Applicants should refer to file number 5706.

THE WINNIPEG GENERAL HOSPITAL

IS RECRUITING

1. CLINICAL SUPERVISORS IN MEDICINE & SURGERY
2. GENERAL DUTY NURSES FOR ALL SERVICES

Please send applications direct to:

THE DIRECTOR OF NURSING,
THE WINNIPEG GENERAL HOSPITAL,
WINNIPEG 3, MANITOBA.

SUPERVISOR

MEDICAL AND SURGICAL SUPPLIES

THE QUEEN ELIZABETH HOSPITAL

TORONTO, ONTARIO

519-beds, good salary, 40-hr. work week, pension, 1-mo. vacation & 8 statutory holidays.

Excellent living accommodation if desired.

APPLY: ADMINISTRATOR

Residence, Cook County School of Nursing

NURSES WHO LIVE HERE NEVER STOP LEARNING . . . GROWING

. . . THEY WORK AT

COOK COUNTY HOSPITAL

. . . in one of the Largest Most Stimulating Medical Centers in the World

Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at $340-$372.50 for a 37½ *hour* week. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

CANADA'S CHEMICAL VALLEY

SARNIA, ONTARIO

DIRECTOR OF NURSING SERVICES

Required for modern, fully approved (JCAH) 300-bed well equipped hospital. This progressive industrial city of 45,000 is growing; it is located on the shores of Lake Huron and the St. Clair River.

The hospital has approved schools for nurses, laboratory technologists, x-ray technicians, and is approved for intern training.

Qualifications for applicants include registration in Ontario, at least a Bachelor's degree in administration, and successful experience in the field of nursing education as well as in administration.

For more details and literature concerning the position and Sarnia, write to:

PERSONNEL DIRECTOR
SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO

VICTORIAN ORDER OF NURSES FOR CANADA

has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

- Opportunity for promotion.
- Transportation while on duty.
- Vacation with pay.
- Retirement annuity benefits.

For further information write to:

Director in Chief,
Victorian Order of Nurses for Canada
5 Blackburn Ave., Ottawa 2, Ont.

UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $250 to $290 gross per month. Differential for evening and night duty. Residence accommodation if desired.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,
SASKATOON, SASKATCHEWAN

REGISTERED NURSES

Required by several of the nineteen (19) hospitals in Saskatchewan's beautiful Northwest. This area has excellent recreational facilities. General Duty Nurses: 40-hr. 5-dy. wk. with generous paid holidays. Excellent residence facilities. Salary $260 — $320.

Superintendent of Nursing: Several required. Wonderful working conditions with first class residence facilities. Salary $300 — $385.

Further information can be obtained, & application submitted to Co-ordinator,
REGIONAL HOSPITAL COUNCIL, 1165 MAIN STREET, NORTH BATTLEFORD, SASKATCHEWAN.

WOODSTOCK GENERAL HOSPITAL

WOODSTOCK, ONTARIO

REQUIRES INSTRUCTORS FOR

1. SCIENCE. 2. MEDICAL CLINICAL. 3. SURGICAL CLINICAL.
4. TEACHING AND SUPERVISION OF CERTIFIED NURSING ASSISTANTS.

HEAD NURSES — SURGICAL AND MEDICAL 3-11 P.M.

GENERAL STAFF NURSES — EMERGENCY, OPERATING ROOM AND ALL DEPARTMENTS.

GOOD PERSONNEL POLICIES — 5-DAY WEEK.

For further information write:

DIRECTOR OF NURSING, GENERAL HOSPITAL, WOODSTOCK, ONTARIO.

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $255 monthly ($117.50 bi-weekly) if registered in Ontario, $235 monthly ($108.20 bi-weekly) until registered. Annual increment $10 monthly ($4.60 bi-weekly) for three (3) years. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12-days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

DIRECTOR -- SCHOOL OF NURSING

For a school of 90-students, organized independently of Nursing Services.

The school program follows the pattern of 2-years of nursing education plus 1-year of internship.

Requirements: Degree & experience in the administration of a nursing education program.

Apply to: R. Buckner, Administrator,

Metropolitan General Hospital,
Windsor, Ontario.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

NURSES FOR GENERAL DUTY IN ALL SERVICES, INCLUDING OPERATING ROOMS & DELIVERY ROOMS.

For further information write:

THE DIRECTOR OF NURSING

PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

OPERATING ROOM NURSE

(EXPERIENCED)

For new 85-bed General Hospital. Situated in a city of 10,000 population with (2) R.C.A.F. Bases and has many recreational facilities.

APPLY: THE ADMINISTRATOR,

THE PORTAGE HOSPITAL, DISTRICT 18, PORTAGE LA PRAIRIE, MANITOBA

THE PROVINCE OF MANITOBA

requires

A Number of Public Health Nurses to work in rural Health Units

Applicants should be nurses registered in Manitoba preferably with post-graduate training in Public Health Nursing or willingness after one year's employment to take postgraduate training in Public Health.

Salary schedule with R. N. only $3,120-$4,020 per annum.

With R. N. plus certificate in Public Health Nursing $3,480-$4,380 per annum.

Full Civil Service benefits, including liberal sick leave with pay, three weeks vacation with pay and pension privileges.

Apply stating training, experience and age to:

THE DIRECTOR,
PUBLIC HEALTH NURSING SERVICES,
320 SHERBROOK STREET, WINNIPEG, MAN.

SARNIA, ONTARIO

CERTIFIED NURSING ASSISTANTS

As an employee of our modern well equipped hospital, you may enjoy the excellent opportunities offered as resident of this progressive industrial city.

Positions are available in all services.

SALARY RANGE IS FROM $2,100 TO $2,508.

Excellent employee benefits include 40-hour, 5-day week. Shift differential for evening and night shifts. 9 statutory holidays.

Please apply to:

PERSONNEL DIRECTOR
SARNIA GENERAL HOSPITAL,
SARNIA, ONTARIO

NURSES REQUIRED

at

Roseway Hosp., Shelburne, N.S.

Superintendent of Nurses — required March 1st and immediately

Assistant Superintendent of Nurses
General Hospital: General Duty Nurses
Maternity Nurses
Nursing Assistants

Tuberculosis Hospital: General Duty Nurses
Nursing Assistants

Additional information may be obtained from **Miss K. B. Harvey, R.N., Superintendent of Nurses**

Apply to:

NOVA SCOTIA CIVIL SERVICE COMMISSION
P.O. BOX 943, HALIFAX, NOVA SCOTIA
2064

THE ONTARIO SOCIETY FOR CRIPPLED CHILDREN

92 College St., Toronto 2

requires

Experienced Public Health Nurses

Good salary range & personnel policies

Apply:

SUPERVISOR OF NURSING SERVICES

NURSING POSITIONS AVAILABLE

Starting salary $300-$340 per mo; 40-hr. wk., 4-wk. vacation; 2-wk. sick time allowance; health insurance; living accommodation in nurses' residence; evening & night bonus $40-$30 per mo.; tuition aid for advanced education in nearby universities.

Lenox Hill Hospital is a large General Hospital in the heart of Manhattan, easily accessible to the cultural advantages of the large metropolis.

Write:

DIRECTOR OF NURSING,
LENOX HILL HOSPITAL
76th STREET & PARK AVENUE
(MIDTOWN NEW YORK)

DIETITIAN

(Immediately)

for 250-bed hospital, with School of Nursing.

Salary commensurate with training and experience.

Apply to:

Miss Noreen Flanagan, Administrator,
MUNICIPAL HOSPITAL, MEDICINE HAT, ALBERTA

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES

OPPORTUNITIES
REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, AND CERTIFIED AUXILIARY NURSES

for Hospital Positions and Public Health Positions in Outpost Nursing Stations, Health Centres and Field Positions in the Provinces, Eastern Arctic Northwest Territories and the Yukon Territory.

SALARIES

(1) Public Health Nursing Supervisors: up to $5,220 depending upon qualifications and location.

(2) Directors of Nursing in Hospitals: up to $4,950 depending upon qualifications and location.

(3) Public Health Staff Nurses: up to $3,780 per year depending upon qualifications and location.

(4) Hospital Staff Nurses: up to $3,540 per year depending upon qualifications and location.

(5) Certified Nursing Assistants or Licensed Practical Nurses: up to $200 per month depending upon qualifications and location.

• Room, Board and Laundry in residence at reasonable rates. Statutory holidays. Three weeks' annual leave with pay. Generous sick leave credits. Hospital-Medical and superannuation plans available.

• Special pay and leave allowances for those posted to isolated areas.

For interesting, challenging, satisfying work apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.